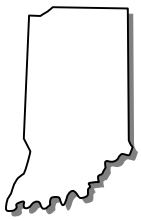
Systems Unit



INDIANA HEALTH COVERAGE PROGRAMS

Systems Documentation - Provider Relations (Volume 1)

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Address any comments concerning the contents of this manual to:

EDS Systems Unit
950 North Meridian Street, 11th Floor
Indianapolis, IN 46204
Fax: (317) 488-5194

Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	January 2000	Multiple	Package C updates	Heather Wisnieski
Version 2.0	2000	All 98-109	New format Update Provider Base Window and Text	Ron Parrish
Version 3.0	July 2001	All	Rendering/billing CSR changes and combined all TP Users Guides-Provider Relations into one manual	Karen Girgis
Version 4.0	March 2004	All	HIPAA updates, repaginate to print double-sided, converted fonts and margins to style guide standards, changed name throughout to *Systems Documentation* from *Users Guide.* Added CPT/CDT disclaimer.	HIPAA Publications

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Section 1: Main Menu Window

Introduction

The main menu is the initial window viewed upon entry to Indiana*AIM*.

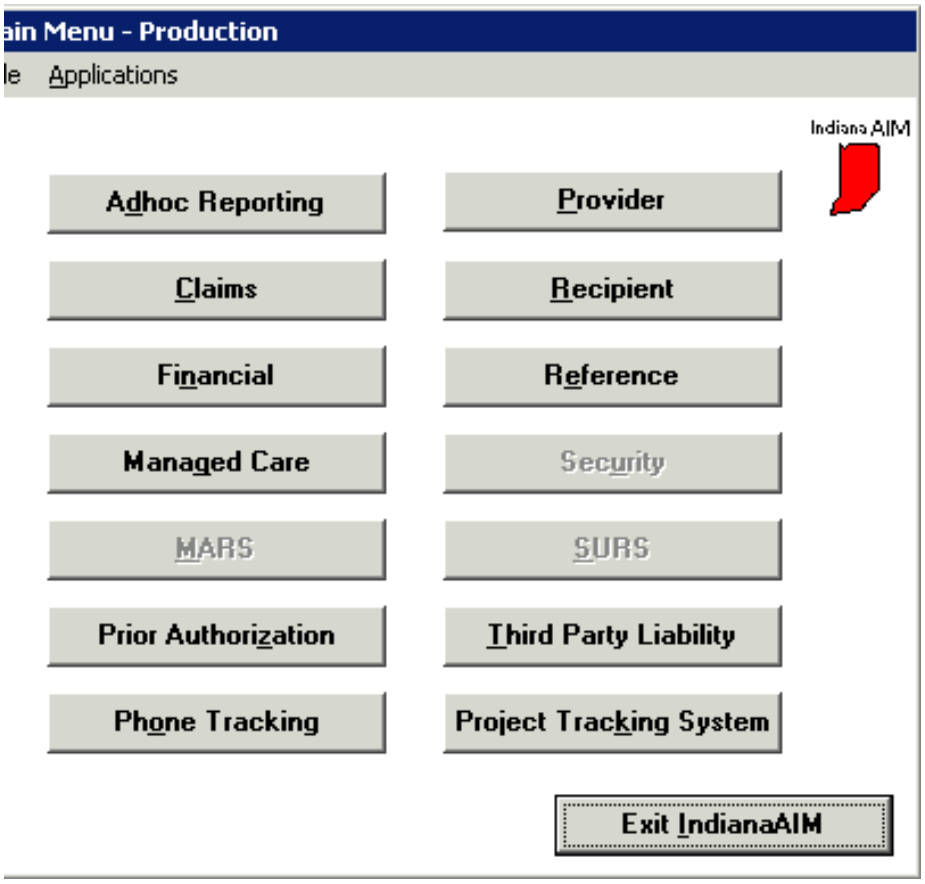

Figure 1.1 – Indiana*AIM* Main Menu Window

File	Applications
Exit Indiana*AIM*	Adhoc Reporting
	Claims
	Financial
	Managed Care
	MARS
	Prior Authorization
	Provider
	Recipient
	Reference
	Security
	SURS
	Third Party Liability
	Project Tracking System

Figure 1.2 – Main Menu Menu Tree

This is the menu tree for the Main Menu. The menu titles on this illustration reflect the overall menu commands and window options on the Main Menu.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available. A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection has the following option:

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Applications

These menu option access the following functional areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting main menu

Claims – Click to access the Claims main menu

Financial – Click to access the Financial main menu

Managed Care – Click to access the Managed Care main menu

MARS – Click to access the MARS main menu

Prior Authorization – Click to access the Prior Authorization main menu

Phone Tracking – Click to access the Phone Tracking main menu

Provider – Click to access the Provider main menu

Recipient – Click to access the Recipient main menu

Reference – Click to access the Reference main menu

Security – Click to access the Security main menu

SURS – Click to access the SURS main menu

Third Party Liability – Click to access the Third Party Liability main menu

Project Tracking System – Click to access the RPTS main menu

Field Codes

None

System Information

PBL – MAIN01.PBL

Window – W_MAIN

Menu – M_MAIN

Data Windows – None

Section 2: Provider Menu Window

Introduction

The Provider Menu is the initial window in the Provider functional area windows. This window accesses the Vendor/Clearinghouse List windows, Enrollment Tracking windows, the PMP Enrollment Tracking windows, the Maintenance windows, the Trading Partner windows, the Correspondence windows, and the Unmatched Attachments windows.

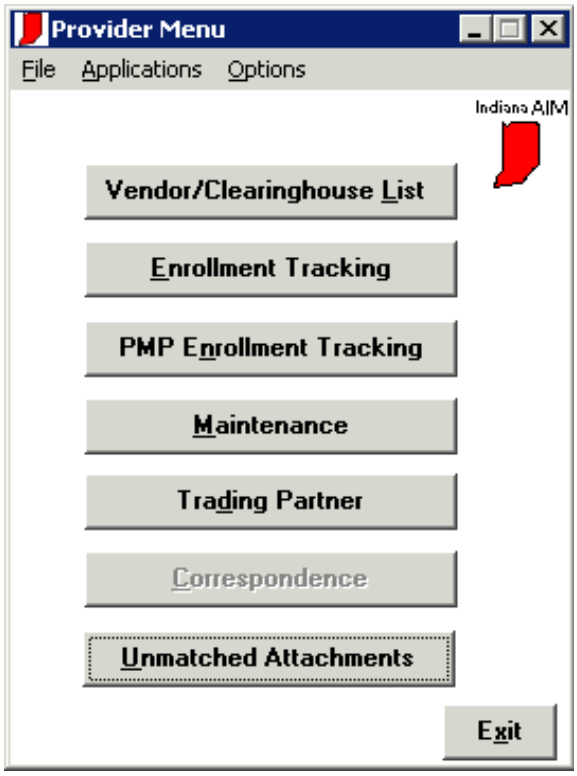

Figure 2.1 – Provider Menu Window

File	Applications	Options
Exit	Adhoc Reporting	Vendor/Clearinghouse List
Exit Indiana*AIM*	Claims	Enrollment Tracking
	Financial	PMP Enrollment Tracking
	MARS	Maintenance
	Prior Authorization	Trading Partner
	Provider	Correspondence
	Recipient	QA Reports
	Reference	EFT Verification
	Security	Unmatched Attachments
	SURS	
	Third Party Liability	

Figure 2.2 – Provider Menu Menu Tree

This is the menu tree for the Provider Menu window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Provider Menu window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection provides the following options:

Exit – Returns to Main Menu

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access Adhoc Reporting information

Claims – Click to access the Claims history files

Financial – Click to access the Financial windows

MARS – Click to access MARS information

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information

SURS – Click to access SURS information

Third Party Liability – Click to access the Third Party Liability windows

Menu Selection: Options

Vendor/Clearinghouse List – Accesses Vendor/Clearinghouse List windows

Enrollment Tracking – Accesses the Enrollment Tracking windows

PMP Enrollment Tracking – Accesses the PMP Enrollment Tracking windows

Maintenance – Accesses the Provider Maintenance windows

Trading Partner – Accesses the Trading Partner window

Correspondence – Accesses the Correspondence window

Unmatch Attachments – Accesses the Unmatch Attachment window

System Information

PBL – PROV02.PBL

Window – W _PROVIDER_ROUTE

Menu – M_PROVIDER_ROUTE

*Data Win*dows – None

System Features

Click Vendor/Clearinghouse List to access Vendor/Clearinghouse List windows.

Click **Enrollment Tracking** to access the Provider Application Selection window.

Click **PMP Enrollment Tracking** to access the PMP Enrollment Tracking windows

Click **Maintenance** to access the Provider Search window.

Click Trading Partner to access the Trading Partner windows.

Click **Correspondence** to access the Correspondence windows.

Click Unmatched Attachments to access the Unmatched Attachments windows.

Section 3: Provider Application Selection Window

Introduction

IFSSA and EDS use the Provider Application Selection window to access the Provider Application Maintenance window by applicant name or enrollment tracking number. The user chooses the method to sort, enter the ETN number or name and start the search by clicking **Search**. The Provider Application Selection window is accessed through the Provider Menu window clicking **Enrollment Tracking** or by entering **Alt+E**.

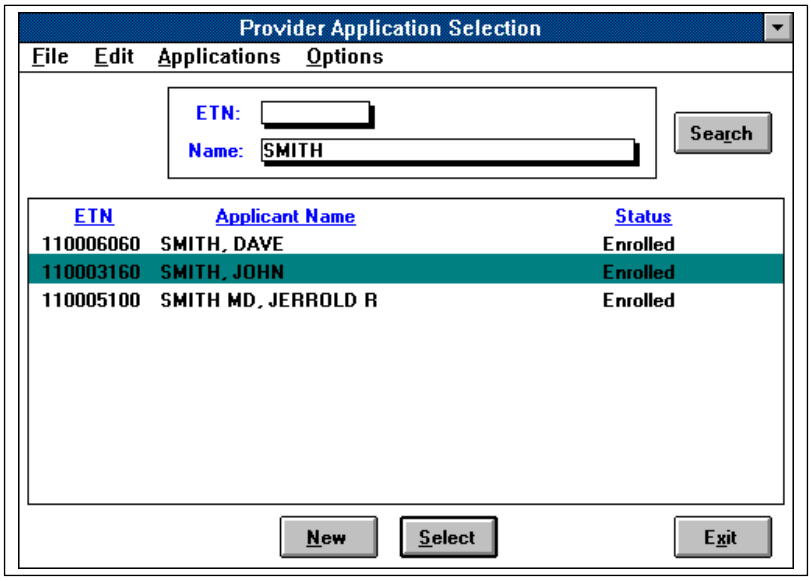

Figure 3.1 – Provider Application Selection Window

File	Edit	Applications	Options
New	Copy	Adhoc Reporting	Aged Tracking Rpt
Select	Paste	Claims	
Print	Cut	Financial	
Exit		Managed Care	
Exit Indiana*AIM*		MARS	
		Prior Authorization	
		Provider	
		Recipient	
		Reference	
		Security	
		SURS	
		Third Party Liability	

Figure 3.2 – Provider Application Selection Menu Tree

This is the menu tree for the Provider Application Selection window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Provider Application Selection window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

New – Opens the Provider Application Selection window

Select – Opens the record of the highlighted provider applicant

Print – Prints the screen, top window, or highlighted data window

Exit – Returns to the Provider Menu window

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection provides the following options:

Copy – Copies text from one area to another

Paste – Inserts text that was cut or copied from another area

Cut – Removes text and places it on the clipboard

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting information

Claims – Click to access the Claims history files

Financial – Click to access the Financial windows

Managed Care – Click to access the Managed Care windows

MARS – Click to access MARS information

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information

SURS – Click to access the SURS windows

Third Party Liability – Click to access the Third Party Liability windows

Menu Selection: Options

This menu selection accesses optional areas in Indiana*AIM*:

Aged Tracking Rpt – Click to access the Aged Tracking Report window

Field Information

Field Name: ETN

Description – Sort option by provider applicant's Enrollment Tracking Number (ETN) (numerically)

Format – Nine alphabetic and numeric characters

Features – Search feature

Edit – 91056, Please enter at least one search field!

To Correct – Verify typing. An ETN number or Name must be entered.

Edit – 91064, Only one search field may be entered!

To Correct – Verify typing. Do not enter an ETN for one provider and the name of another provider.

Edit – 91011, Record not found please try again!

To Correct – Verify typing. The name or enrollment tracking number of the provider applicant must be stored in the enrollment tracking system to be displayed.

Field Name: Name

Description – Provider applicant's name (alphabetically)

Format –Alphabeticcharacters

Features – Search feature

Edit – 91056, Please enter at least one search field!

To Correct – Verify typing. An ETN number or name must be entered.

Edit – 91064, Only one search field may be entered!

To Correct – Verify typing. Do not enter an ETN for one provider and the name of another provider.

Edit – 91011, Record not found please try again!

To Correct – Verify typing. The name or enrollment tracking number of the provider applicant must be stored in the enrollment tracking system in order to be displayed.

Field Name: ETN

Description – Search option by provider applicant's enrollment tracking number (ETN) (user enters the ETN number if known)

Format – Nine alphabetic and numeric characters

Features – None

Edits – None

To Correct – N/A

Field Name: Applicant Name

Description – Search option by provider applicant's name. If the provider applicant is an individual, the user enters the applicant's last name, first name, and middle initial. If provider applicant is a business, the user enters the name of the business.

Format – 39 alphabetic characters

Features – None

Edits – None

To Correct – N/A

Field Name: Status

Description – The provider applicant's status

Format – Approved, Enrolled, Denied

Features – None

Edits – None

To Correct – N/A

System Information

PBL – PROV02.PBL

Window – W_PROVIDER_APPLICATION_LIST

Menu – M_PROV_APPL_SEARCH

Data Windows – DW_PROVIDER_APPLICATION_SEARCH

DW_PROVIDER_APPLICATION_LIST

DW_PROVIDER_APPLICATION_STRUCT

System Features

Double-clicking a listed provider displays the Provider Application Maintenance window with detail information for the selected provider.

Provider application records are listed in ascending order of the selected **Sort** radio button.

Section 4: Provider Application Maintenance Window

Introduction

IFSSA and EDS use the Provider Application Maintenance window to view, update, add, or delete information in the Provider Application Maintenance database. Only authorized users with update privileges have the ability to add new information or change existing data. The Provider Application Maintenance window is accessed through the Provider Application Selection window by selecting **New** or by pressing **Alt+N**. This window also displays when viewing an existing provider applicant record by choosing the applicant by name or **ETN** on the Provider Application Selection window. Subsequent windows are accessed by the option buttons on the Provider Application Maintenance window.

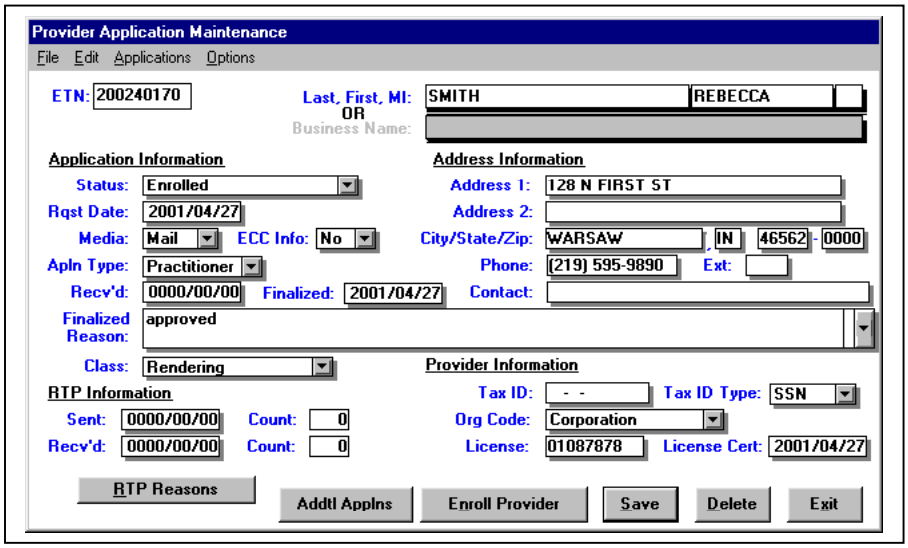

Figure 4.1 – Provider Application Maintenance Window

File	Edit	Applications	Options
Save	Copy	Adhoc Reporting	Print RTP Letter
Delete	Paste	Claims	
Print	Cut	Financial	
Exit		Managed Care	
Audit		MARS	
Exit Indiana*AIM*		Prior Authorization	
		Provider	
		Recipient	
		Reference	
		Security	
		SUR	
		Third Party Liability	

Figure 4.2 – Provider Application Maintenance Menu Tree

This is a menu tree for the Provider Application Maintenance window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Provider Application Maintenance window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

Save – Saves the information previously typed in the Enrollment Tracking System (ETS)

Delete – Deletes a provider applicant record and ETN

Print –Prints the screen, top window, or highlighted data window

Exit – Returns to Provider Application Selection window

Audit – Provides access to the online audit trail window

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy – Copies text from one area to another

Paste – Inserts text cut or copied from another area

Cut – Removes text and places it on the clipboard

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting information

Claims – Click to access the Claims history files

Financial – Click to access the Financial windows

Managed Care – Click to access the Managed Care windows

MARS – Click to access the MARS information

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information

SURS – Click to access the SURS windows

Third Party Liability – Click to access the Third Party Liability windows

Menu Selection: Options

This menu selection accesses other areas in Indiana*AIM*:

Print RTP Letter – Prints return to provider letter

Field Information

Field Name: ETN

Description – Provider applicant enrollment tracking number (ETN)

Format – Nine alphabetic and numeric characters

Features – System generated

Edits – None

To Correct – N/A

Field Name: Last, First, MI

Description – Provider applicant name if applicant is an individual

Format – 39 alphabetic characters (25 characters for last name, 13 characters for first name, one character for middle initial)

Features – N/A

Edit – 91037*,* Last name field is required!

To Correct – Verify typing. Entry is required when the cursor is placed in the 'Last, First, MI' field

Edit – 91037, First name field is required!

To Correct – Verify typing. Entry is required when the cursor is placed in the 'Last, First, MI' field.

Field Name: BUSINESS NAME

Description – Search option by provider applicant name if provider applicant is a corporation (type in the name of the business)

Format – 39 alphabetic characters

Features – N/A

Edits – None

To Correct – N/A

Address Information

Field Name: Address 1

Description – First line of provider applicant mail-to address

Format – 39 alphabetic characters

Features – None

Edit – 5001 Address info must be present!

To Correct – Verify typing. This field is a required entry

Field Name: Address 2

Description – Second line of provider applicant mail-to address if applicable

Format – 39 alphabetic characters

Features – None

Edits – None

To Correct – N/A

Field Name: City

Description – Provider applicant mail-to city

Format – 15 alphabetic characters

Features – None

Edit – 5035, City is invalid!

To Correct – Verify typing. This field is a required entry.

Field Name: State

Description – Provider applicant mail-to state with valid values to include the following:

AL	AK	AZ
AR	CA	CO
CT	DE	DC
FL	GA	HI
ID	IL	IA
KS	KY	LA
ME	MD	MA
MI	MN	MS
MO	MT	NE
NV	NH	NJ
NM	NY	NC
ND	OH	OK
OR	PA	RI
SC	SD	TN
TX	UT	VT
VA	WA	WV
WI	WY	IN

Format – Two alphabetic characters

Features – None

Edit – 91036, Invalid State code!!

To Correct – Verify typing. Entered Data typed in must be one of the valid values for this field

Edit – 91006, Field is required!

To Correct – Verify typing. This field is a required entry

Field Name: ZIP

Description – Provider applicant five-digit and optional four-digit ZIP code

Format – Nine alphabetic and numeric characters

Features – None

Edit – 91059, ZIP code must be five characters!

To Correct – Verify typing. This field is a required entry and must be five characters long.

Edit – 91029, ZIP code must be numeric!

To Correct – Verify typing. The entry must be numeric characters

Edit – 91058, ZIP code suffix must be four characters!

To Correct – Verify typing. If data is entered, it must be four characters long.

Edit – 91029, ZIP code suffix must be numeric!

To Correct – Verify typing. The entry must be numeric characters

Field Name: Phone

Description – Provider applicant phone number

Format – 10 alphabetic characters

Features – None

Edit – 91061, Phone number must be 10 digits!

To Correct – Verify typing. This field is a required entry and must be 10 characters long.

Edit – 91029, Phone number must be numeric!

To Correct – Verify typing. Phone number must contain numeric characters

Field Name: Ext

Description – Provider applicant phone number extension

Format – Four numeric characters

Features – None

Edit – 91029, Phone number extension must be numeric!

To Correct – Verify typing. The phone number extension must contain numeric characters

Field Name: Contact

Description – The person with whom EDS corresponds at the provider applicant's place of business

Format – 30 alphabetic characters

Features – None

Edit – 91037, Contact field is required!

To Correct – Verify typing. This field is a required entry.

Edit – 91031, Contact must be alpha!

To Correct – Verify typing. The field must contain alphabetic characters.

Field Name: Tax ID

Description – Provider applicant's IRS identifier

Format – Nine alphabetic and numeric characters

Features – None

Edit – 91038, Tax ID must be 9 characters!

To Correct – Verify typing. This field is a required entry and must be nine characters long.

Edit – 91029, Tax ID must be numeric!

To Correct – Verify typing. The field must contain numeric characters

Field Name: Tax ID Type

Description – Type of IRS identifier

Format – Valid values include the following:

- FEIN
- SSN

Features – Drop-down box that default to SSN if nothing is selected.

Edits – None

To Correct – N/A

Field Name: Org Code

Description – Type of organization, provider practice, or business setup type. Valid values include the following:

- Corporation
- Estate/Trust
- Government Owned
- Not-for-profit
- Partnership
- Public Service Corp
- Sole Proprietor

Format – N/A

Features – Drop-down list box

Edits – None

To Correct – N/A

Field Name: License

Description – Provider applicant license number, if applicable

Format – Appropriate alphabetic and neumeric characters applicable to the state the license was issued.

Features – None

Edit – 5236, Provider license not on file! Save Anyway?!

To Correct – Verify typing. The license number must match a valid license number on the Health Professions Bureau valid license tape. An updated tape is loaded into the Enrollment Tracking System quarterly. The analyst has the option or overriding the edit for out-of-state or newly licensed providers.

Edit – 5092, License number must be five to 10 numeric digits!

To Correct – Verify typing. The license number must be at least five, but no more that 10 numeric (0-9) digits.

Edit – 91029, License number must be numeric!

To Correct – Verify typing. The license number must be numeric characters

Field Name: License Cert

Description – The date a license was validated

Format – Eight numeric characters

Features – System generated with current date when license information is entered but may also be manually updated

Edit – 91001, Invalid date (CCYYMMDD)!

To Correct – Verify typing. The date must be typed in the above format and be numeric characters

Edit – 91003, Date is required!

To Correct – Verify typing. This field is a required entry when a license number has been typed in.

Application Information

Field Name: Status

Description – Status of the application in process. Valid values include the following:

- Approved
- Awaiting Additional Info
- Awaiting Initial Info
- Denied
- Enrolled
- In Process By EDS
- System Converted

Format – N/A

Features –Status is system-generated each time a date is entered. The status depends on the date entered.

Edit – 91037, Status field is required!

To Correct – Verify typing. This field is system generated and must *not* be deleted

Field Name: Rqst Date

Description – Date the application was requested

Format – Eight alphabetic and numeric characters

Features – System-generated current date. User can override if needed.

Edit – 91001, Invalid date (CCYYMMDD)!

To Correct – Verify typing. This field is required and must be entered in the above format

Edit – 91037, Rqst Date is required!

To Correct – Verify typing. This field is required and must not be deleted if system generated

Field Name: Media

Description – The format by which the provider application was requested. Valid values include the following

- Fax
- Mail
- Phone

Format – N/A

Features – Drop-down box

Edit – 91037, Request type field is required!

To Correct – Verify typing. This field is a required entry.

Field Name: ECC Info

Description – Indicator to display if provider requested electronic claims capture information with valid values to include the following:

- No
- Yes

Format – N/A

Features – Drop-down list box

Edits – None

To Correct – N/A

Field Name: Apln Type

Description – Type of application requested by the provider. Valid values include the following:

- Institutional
- Practitioner

Format – N/A

Features – Drop-down box

Edit – 91037, Application type field is required!

To Correct – Verify typing. Selection from the drop-down box is required.

Field Name: Recv'd

Description – Date the completed application was received by EDS for the first time

Format – Eight alpha and numeric characters

Features – None

Edit – 5147, Received Date may not be less that Rqst Date!

To Correct – Verify typing. The date the application was received by EDS cannot be prior to the date the application was sent to the provider.

Edit – 91037, Received date field is required!

To Correct – Verify typing. This field is a required entry to finalize a provider record.

Edit – 91001, Invalid date (CCYYMMDD)!

To Correct – Verify typing. The date must be in the above format.

Edit – 91002, Date must be numeric!

To Correct – Verify typing. The date must contain numeric characters.

Field Name: Finalized Reason

Description – Description of the finalized application in free form comment field up to 250 characters with the exception of the following four reasons:

- *Approved*
- *The Health Professions Bureau has notified EDS that your license has been revoked or expired.*
- *The provider type and/or specialty you submitted is not eligible to enroll (please refer to the IHCP Provider Manual, Chapter 4).*
- *You have previously been convicted of Medicaid fraud*.

Format – N/A

Features – Drop-down list box

Edit – 5154, Description may not exceed 250 characters!

To Correct – Verify typing. The free text area may not be over 250 characters long.

Field Name: Finalized

Description – Date the application was finalized (approved or denied)

Format – Eight numeric characters

Features – None

Edit – 5138, Finalized date may not be less than Received Date!

To Correct – Verify typing. The date of finalization must not be earlier than the date the completed application was received by EDS.

Edit – 5139, Reason is required with Finalized Date!

To Correct – Verify typing. When a finalized date is entered, a finalized reason must be chosen before saving

Edit – 91002, Date must be numeric!

To Correct – Verify typing. Entry must be numeric characters.

Edit – 91001, Invalid date (CCYYMMDD)!

To Correct – Verify typing. Date must be entered in the above format

Edit – 91003, Date is required!

To Correct – Verify typing. This is a system-generated field and must *not* be deleted

Field Name: Class

Description – Type of billing classification for the provider

Format – Valid values include the following:

- Billing
- Dual Role
- Group
- Rendering

Features – Drop-down box

Edits – None

To Correct – None

Field Name: Sent

Description – Date the application was returned to the provider

Format – Eight numeric characters

Features – System generated with the current date when an RTP reason is chosen, but can also be manually updated

Edit – 5140,Please add RTP Reason before RTP Date!

To Correct – Verify typing. An RTP reason must be chosen before entering an RTP date since the RTP is system generated.

Edit – 5138, RTP Sent Date may not be less than Received Date!

To Correct – Verify typing. The date of the RTP must not be earlier than the date the completed application was received by EDS.

Edit – 5141, RTP Reason is required for RTP Sent date!

To Correct – Verify typing. An RTP reason must be chosen in order to save the RTP date

Edit – 5142, RTP Sent date is required for RTP Reasons!

To Correct – Verify typing. This is a system generated field and must *not* be deleted

Edit – 91002, Date must be numeric!

To Correct – Verify typing. Entry must be numeric characters.

Edit – 91001, Invalid date (CCYY/MM/DD)!

To Correct – Verify typing. The date must be entered in the above format and is required

Field Name: Count

Description – Number of times the application was returned to the provider

Format –Two numeric characters

Features – System generated

Edits – None!

To Correct – N/A

Field Name: Recv'd

Description – Date the returned application is received by EDS

Format – Eight numeric characters

Features – None

Edit – 5138, RTP Recv'd Date may not be less than Received Date!

To Correct – Verify typing. The date the returned application is received by EDS cannot be prior to the date the application was received for the first time.

Edit – 91002, Date must be numeric!

To Correct – Verify typing. Entry must be numeric characters.

Edit – 91001, Invalid date (CCYY/MM/DD)!

To Correct – Verify typing. The date must be entered in the above format and is required

Edit – RTP Received field is required!

To Correct – Verify typing. This field is a required entry to finalize a provider record

Field Name: Count

Description – The number of times the returned application has been received by EDS

Format – Two numeric characters

Features – System generated

Edits – None

To Correct – N/A

Other Edits

Edit – 5146, Application Status finalized - No further editing!

To Correct – Application is finalized

Edit – 91060, Save current window before continuing!

To Correct – User must save the open window before attempting to add more information in another window

Edit – 91069, Must save current window before continuing!

To Correct – User must save the open window before attempting to add more information in another window

Edit – 5087, Application must be approved to enroll provider!

To Correct – Verify that the Finalized Reason displays **approved** and the Status field displays **enrolled** on the Provider Application Maintenance window before **Enroll Provider** is clicked.

Edit – 5088, Provider has already been enrolled!

To Correct – Verify typing. Provider applicant must not already be on the provider database.

System Information

PBL – PROV02.PBL

Window – W_PROVIDER_APPLICATION_MAINT

Menu – M_PROVIDER_APPLICATION

Data Windows – DW_PROVIDER_APPLICATION_MAINT

DW_PROVIDER_APPLICATION_RTP

DW_PROVIDER_APPLICATION_GRP

DW_PROVIDER_APPLICATION_PREV

System Features

Double-click **on a listed previous number or group number** to display the appropriate update window.

Application form letter printing can be accessed through the Print menu.

Most edits occur on the Save operation.

Previous Number Window is populated from Provider Re-enrollment Conversion

Double-click **Maintain Group** to update group information.

Double-click **RTP Reasons** to add or view RTP reasons.

Section 5: Provider Application RTP Reasons Window

Introduction

IFSSA and EDS use the Provider Application RTP Reasons window to view, update or add Return To Provider reasons to the Provider Application Maintenance database. Only authorized users with update privileges have the ability to add new information or change existing data. The user can also enter more than one RTP reason by clicking on multiple reasons from a drop-down list box. The Provider Application RTP Reasons window is accessed through the Provider Application Maintenance window by selecting **RTP Reasons** or by pressing **Alt+R**.

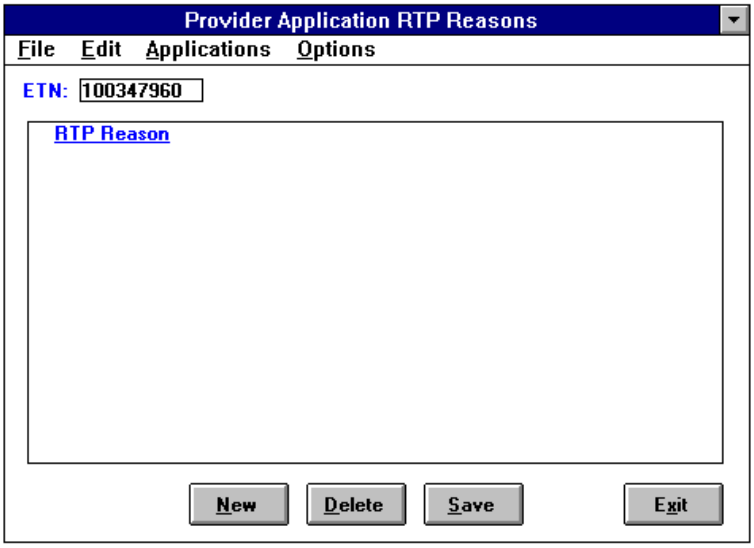

Figure 5.1 – Provider Application RTP Reasons Window

File	Edit	Applications	Options
New	Copy	Adhoc Reporting	
Save	Paste	Claims	Print RPT Letter
			Inquire
Print	Cut	Financial	
Exit		Managed Care	
Audit		MARS	
Exit Indiana*AIM*		Prior Authorization	
		Provider	
		Recipient	
		Reference	
		Security	
		SURS	
		Third Party Liability	

Figure 5.2 – Provider Application RTP Reasons Menu Tree

This is the menu tree for the Provider Application RTP Reasons window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Provider Application RTP Reasons window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

New – Opens the Provider Application RTP Reason window

Print – Prints the screen, top window, or highlighted data window

Save – Saves RTP reason information previously entered into the ETS

Exit – Returns to Provider Application Maintenance Window

Audit – Accesses the online audit trail windows

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy –Transfers text from one area to another

Paste – Inserts text cut or copied from another area

Cut – Removes text and places it on the clipboard

Menu Selection: Applications

This menu selection accesses the following areas in IndianaAIM:

Adhoc Reporting – Click to access the Adhoc Reporting information

Claims – Click to access the Claims history files

Financial – Click to access the Financial windows

Managed Care – Click to access the Managed Care windows

MARS – Click to access MARS information

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information

SURS – Click to access the SURS windows

Third Party Liability – Click to access the Third Party Liability windows

Menu Selection: Options

Print RTP Letter – Allows access to print PRV-9007-R with the chosen RTP reason

Inquire – Waiting for an answer

Field Information

Field Name: RTP Reason

Description – Reason the application was returned to provider with valid values include the following:

- Care Coordination Cert (NASW)
- Copy of Drivers License
- Copy of Insurance
- Copy of License
- County of Service
- Completed Schedule A
- Completed Schedule B
- Completed Schedule C
- Date of Signature
- Employee Identification Number
- Copy of EMS Certification
- Copy of HCFA Approved Letter
- Copy of Motor Carrier Authority
- Name of Authorized Representative
- Prosthetic/Orthodic Reg Number
- Business Address
- Provider Name
- Specialty Code
- Title
- Signature
- Social Security Number
- Type of Provider Entity

Format – N/A

Features – Drop-down list box

Edit – 8004, No changes keyed!

To Correct – Verify typing. The user must enter data in order to save

Edit – 5154, Description may not exceed 250 characters!

To Correct – Verify typing. The user may not enter a free text RTP reason over 250 characters

Edit – 91037, Field is required!

To Correct – Verify typing. An RTP reason is a required entry if an RTP date is entered.

Section 6: Provider Aged Tracking Report Window

Introduction

The Provider Aged Tracking Report is accessed by selecting Options and then Aged Tracking Report on the Provider Application Selection window. The report can be sorted by Request Date or Provider Name. When the report is displayed in the window, the user can print the report on a local printer.

The Date and Time displayed denotes the search time.

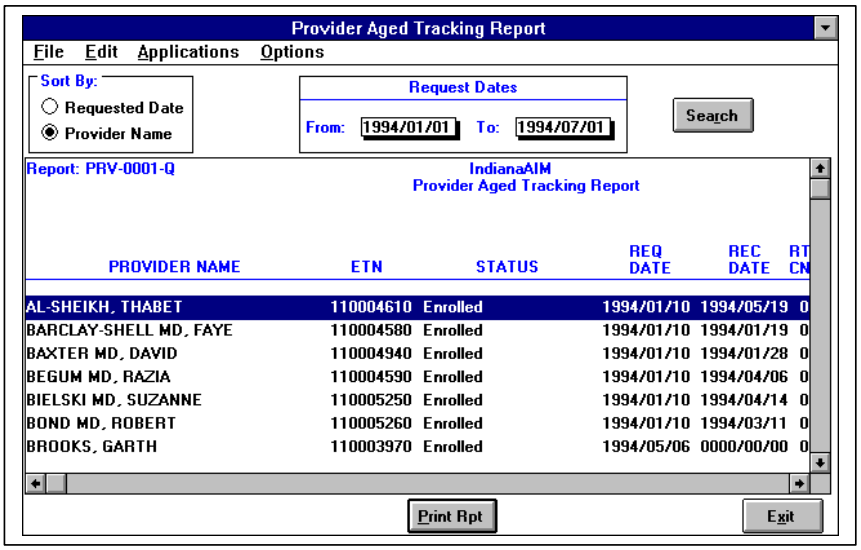

Figure 6.1 – Provider Aged Tracking Report Window

File	Edit	Applications	Options
Print	Copy	Adhoc Reporting	Print Rpt
Exit	Paste	Claims	
Exit Indiana*AIM*	Cut	Financial	
		Managed Care	
		MARS	
		Prior Authorization	
		Provider	
		Recipient	
		Reference	
		Security	
		SURS	
		Third Party Liability	

Figure 6.2 – Provider Aged Tracking Report Menu Tree

This is the menu tree for the Provider Aged Tracking Report window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Provider Aged Tracking Report window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

Print – Prints the window, the screen, or the data in the window

Exit – Returns to the Provider Application Selection window

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy –Transfers the copied text to another area

Paste – Inserts text cut or copied from another area

Cut – Removes the text and places it on the clipboard

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting information

Claims – Click to access the Claims history files

Financial – Click to access the Financial windows

Managed Care – Click to access the Managed Care windows

MARS – Click to access MARS information

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information

SURS – Click to access the SURS windows

Third Party Liability – Click to access the Third Party Liability windows

Menu Selection: Options

Print Rpt – Prints the aged tracking report on a local printer

Field Information

Field Name: Sort by

Description- Selects to sort by either Date Requested or Provider Name

Field Name: From Request Date

Description – Selects the *from* date that the application request was received by EDS

Format – Eight alphabetic and numeric characters

Features – None

Edit 91002 – Date must be numeric!

Edit 91001 – Invalid Date (CCYYMMDD)!

Edit 91003 – Date is required!

Edit 91090 – Please enter From and To dates!

Edit 91077 – From Date Request must be less than or equal to Date Request!

Edit 91011 – Record not found - please try again!

To Correct – Verify typing! Dates must be numeric and in (CCYYMMDD) format.

Field Name: To Request Date

Description – Selects the *to* date that the application request was received by EDS

Format – Eight alphabetic and numeric characters

Features – None

Edit 91002 – Date must be numeric!

Edit 91001 – Invalid Date (CCYYMMDD)!

Edit 91003 – Date is required!

Edit 91090 – Please enter From and To dates!

Edit 91077 – From Date Request must be less than or equal to Date Request!

To Correct – Verify typing. Dates must be numeric and in (CCYYMMDD) format.

Field Name: Provider Name

Description – Provider's name

Format – 39 alphabetic characters

Features – Display only

Edits – None

To Correct – N/A

Field Name: ETN

Description – Enrollment tracking number—Identifies the enrollment application

Format – Nine alphabetic and numeric characters

Features – Display only

Edits – None

To Correct – N/A

Field Name: Status

Description – Description of possible statuses

Forma – One alphabetic and numeric characters

Features – Display only

Edits – None

To Correct – N/A

Field Name: Req Date

Description – Date the application request was received by EDS

Format – Eight alphabetic and numeric characters

Features – Display only

Edits– None

To Correct – N/A

Field Name: Rec Date

Description – Date the application was received

Format – Eight alphabetic and numeric characters

Features – Display only

Edits – None

To Correct – N/A

Field Name*: RTP CNT*

Description – Accumulator of the number of times something has been returned from a provider

Format – Two alphabetic and numeric characters

Features – Display only

Edits– None

To Correct – N/A

Field Name: RTP SENT DATE

Description – Date the RTP object was sent

Format – Eight alphabetic and numeric characters

Features – Display only

Edits – None

To Correct – N/A

Field Name: RTP REC DATE

Description – Date the RTP object was returned to the account

Format – Eight alphabetic and numeric characters

Features – Display only

Edits – None

To Correct – N/A

System Information

PBL – PROV01.PBL

Window – W_PROV_APPLN_TRACKING_RPT

Menu – M_PROV_LIST_SEARCH

Data Windows – DW_PROV_TRACKING_SEARCH

DW_PROV_APPLN_TRACKING_RPT

System Features

Click **Exit** to close the window.

Click **Print Rpt** to print the report.

The window scrolls vertically and horizontally to display all the data meeting the search criteria.

Section 7: PMP Application Selection Window

Introduction

The PMP Application Selection window is the initial window viewed on entry to the PMP Enrollment Tracking application. This window accesses the PMP Enrollment Tracking maintenance screens.

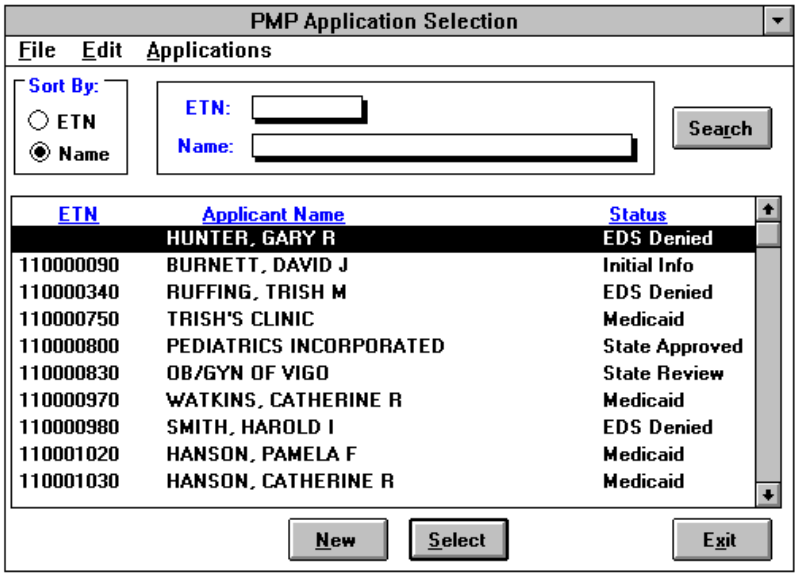

Figure 7.1 – PMP Application Selection Window

File	Edit	Applications
New	Copy	Adhoc Reporting
Select	Paste	Claims
Print	Cut	Financial
Exit		Managed Care
Exit Indiana*AIM*		MARS
		Prior Authorization
		Provider
		Recipient
		Reference
		Security
		SURS
		Third Party Liability

Figure 7.2 – PMP Application Selection Menu Tree

This is an illustration of a menu tree for the PMP Application Selection window. The menu titles on this illustration reflect the overall menu commands and window options on the PMP Application Selection window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu allows the following options:

New – Accesses a blank PMP Application Maintenance screen used to log a new addendum request

Select – Accesses the PMP Application Maintenance window for the highlighted addendum

Print – Prints the screen, the current window, or the data window

Exit – Returns to the Provider Menu

Exit Indiana*AIM* – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy –Transfers the copied text to another area

Paste – Inserts cut or copied text from another area

Cut – Removes text and places it on the clipboard

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting main menu

Claims – Click to access the Claims main menu

Financial – Click to access the Financial main menu

Managed Care – Click to access the Managed Care main menu

MARS – Click to access the MARS main menu

Prior Authorization – Click to access the Prior Authorization main menu

Provider – Click to access the Provider main menu

Recipient – Click to access the Recipient main menu

Reference – Click to access the Reference main menu

Security – Click to access the Security main menu

SURS – Click to access the SURS main menu

Third Party Liability – Click to access the Third Party Liability main menu

Field Information

Field Name: Sort By

Description – Indicates if addenda should be sorted by the applicant's name or by the PMP enrollment tracking number (ETN)

Format – Radio buttons choose ETN or Name

Features – None

Edits – None

To Correct – N/A

Field Name: ETN

Description – ETN on which to initiate a search. This is either the provider's Indiana Health Coverage Programs (IHCP) identification number or the ETN assigned under the IHCP enrollment tracking system.

Format – Nine alphabetic and numeric characters

Features – Search field

Edits – None

To Correct – N/A

Field Name: Name

Description – Individual or business name on which to initiate a search

Format – 39 alphabetic character

Features – Search field

Edits – None

To Correct – N/A

Field Name: ETN

Description – ETN used to identify addendum request. This is either the provider's IHCP identification number or the ETN assigned under the IHCP enrollment tracking system

Format – Nine alphabetic and numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Applicant Name

Description– Individual or business name listed on the addendum request

Format – 39 alphabetic characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Status

Description – Current status of the addendum

Format – 20 alphabetic characters

Features – Protected, display only

Edits – None

To Correct – N/A

Other Messages

Edit – 91056, Please enter at least one search field!

To Correct – Type either an ETN or Name for a search.

Edit – 91064, Only one search field may be entered!

To Correct – Delete either the name or ETN from the search criteria.

System Information

PBL – PROV07.PBL

Window – W_PMP_APPLN_LIST

Menu – M_PROV_LIST_SEARCH

Data Windows – DW_PMP_APPLN_LIST

DW_PROV_APPLN_SEARCH

System Features

Click **Search** to initiate a search on the ETN or name entered.

Click **New** to access a blank PMP Application Maintenance screen to log a new request.

Click **Select** to access the PMP Application Maintenance screen of the highlighted applicant.

Click **Exit** to return to the Provider menu.

Section 8: PMP Application Maintenance Window

Introduction

The PMP Application Maintenance window is used by IFSSA and EDS to view, add, or update a provider's request for enrollment as a Primary Medical Provider. This screen is used to capture the information required to mail a Primary Medical Provider addendum. It also allows the user to view the current status of a provider's addendum. This window is accessed from the PMP Application Selection Window.

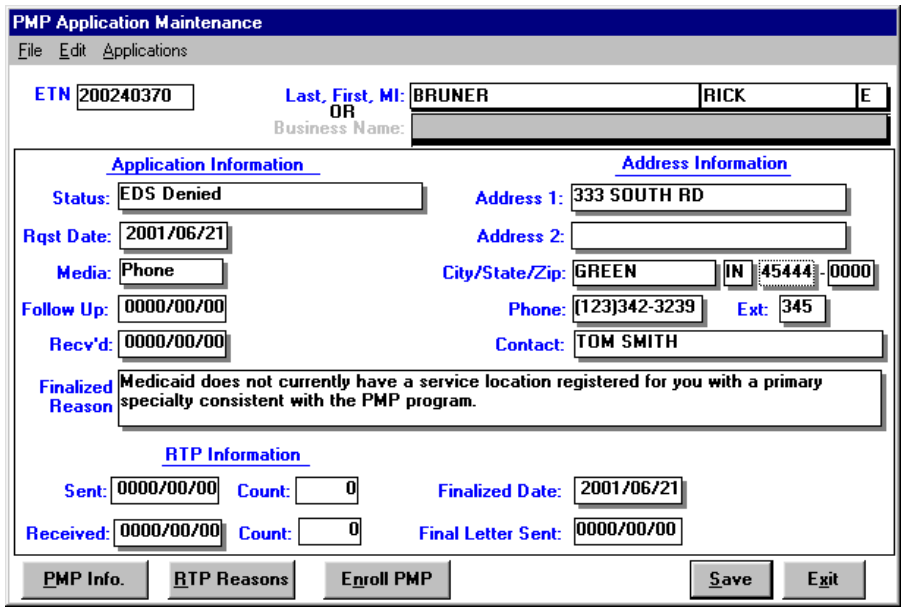

Figure 8.1 – PMP Application Maintenance Window

File	Edit	Applications
Save	Copy	Adhoc Reporting
Delete	Paste	Claims
Print	Cut	Financial
Exit		Managed Care
Audit		MARS
Exit Indiana*AIM*		Prior Authorization
		Provider
		Recipient
		Reference
		Security
		SURS
		Third Party Liability

Figure 8.2 – PMP Application Maintenance Menu Tree

This is the menu tree for the PMP Application Maintenance window. The menu titles on this illustration reflect the overall menu commands and window options on the PMP Application Maintenance window

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

Save – Saves the current screen

Delete – Deletes the current addendum from the PMP Enrollment Tracking System

Print – Prints the entire screen or the current window

Exit – Returns to the PMP Application Selection Menu

Audit – Returns the audit trail for a column

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy –Transfers the copied text to another area

Paste – Inserts text cut or copied from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting main menu

Claims – Click to access the Claims main menu

Financial – Click to access the Financial main menu

Managed Care – Click to access the Managed Care main menu

MARS – Click to access the MARS main menu

Prior Authorization – Click to access the Prior Authorization main menu

Provider –Click to access the Provider main menu

Recipient – Click to access the Recipient main menu

Reference – Click to access the Reference main menu

Security – Click to access the Security main menu

SURS – Click to access the SURS main menu

Third Party Liability – Click to access the Third Party Liability main menu

Field Information

Field Name: ETN

Description – Requesting provider's IHCP identification number or IHCP enrollment tracking number. By entering the nine numeric characters and pressing Search, the user can perform a search using fuzzy logic.

Format – Nine numeric characters

Features – System protected on updates

Edit – 5157, The ETN must be 9 char. in length!

To Correct – Verify and re-enter ETN.

Edit – 5158, The ETN must be numeric!

To Correct – Verify and re-enter ETN.

Edit – 5159, PMP can not be out of state providers!

To Correct – PMP applicant must have an Indiana address. Verify typing and re-enter. If the address is out of state, deny the application.

Edit – 5160, ETN is Not a Valid Provider or Appln!

To Correct – The provider must exist in either IHCP ETS or be IHCP enrolled. Verify typing and re-enter. If the number is not valid, deny the application.

Edit – 5174, Prov has No Service Loc w/Valid PMP Spec!

To Correct – No correction is necessary. The addendum is denied since the provider is not eligible for PMP based on IHCP files. Click **OK**.

Edit – 5175, ETN already on File. No duplicates allowed.

To Correct – Verify typing and re-enter if necessary.

Edit – 5179, Copy the Provider Enrollment Information?

To Correct – Choose **yes** to copy the IHCP enrollment information to the PMP request.

Edit – 91060, Save current window before continuing!

To Correct – Click **Save**.

Field Name: Last Name

Description – Last name of provider requesting addendum. By entering the nine numeric characters and pressing Search, the user can perform a search using fuzzy logic.

Format – 25 alphabetic characters

Features – None

Edit – 91037, Field is required!

To Correct – Enter the last name.

Field Name: First Name

Description – First name of provider requesting addendum. By entering the nine numeric characters and pressing Search, the user can perform a search using fuzzy logic.

Format – 13 alphabetic characters

Features– None

Edit – 91037, Field is required!

To Correct – Enter the first name.

Field Name: Middle Initial

Description – Middle initial of provider requesting addendum

Format – One alphabetic character

Features – None

Edits– None

To Correct – N/A

Field Name: Business Name

Description – Incorporated name of provider requesting addendum

Format – 39 alphabetic characters

Features – None

Edits – None

To Correct – N/A

Field Name: Address 1

Description – Street address to which addendum is to be mailed

Format – 30 alphabetic characters

Features – If provider is on the IHCP enrollment tracking system, this field is populated from ETS.

Edit – 5001, Address info must be present!

To Correct – Enter address information.

Field Name: Address 2

Description – Additional address information, if necessary

Format – 30 alphabetic characters

Features – If provider is on the IHCP enrollment tracking system, this field is populated from ETS.

Edits – None

To Correct – N/A

Field Name: City

Description – City used for mailing

Format – 15 alphabetic characters

Features – If provider is on the IHCP enrollment tracking system, this field is populated from ETS.

Edit – 5035, City is invalid!

To Correct – Verify typing and re-enter.

Field Name: State

Description – State used for mailing

Format – Two alphabetic and numeric characters

Features – If provider is on the IHCP enrollment tracking system, this field is populated from ETS.

Edit – 91006, Field is required!

To Correct – Enter state abbreviation

Edit – 91036, Invalid state code!

To Correct – Verify typing and re-enter

Field Name: ZIP

Description – Provider applicant five-digit ZIP code used for mailing

Format – Five numeric characters

Features – If provider is on the IHCP enrollment tracking system, this field is populated from ETS.

Edit – 91029, Must be numeric!

To Correct – Verify typing and re-enter.

Field Name: ZIP Suffix

Description – Provider applicant four-digit ZIP code suffix used for mailing

Format – Four numeric characters

Features – If provider is on the IHCP enrollment tracking system, this field is populated from ETS.

Edit – 91029, Must be numeric!

To Correct – Verify typing and re-enter.

Edit – 91058, Must be 4 characters!

To Correct – Verify typing and re-enter.

Field Name: Phone

Description – Phone number of requester

Format – Nine numeric characters

Features – If provider is on the IHCP enrollment tracking system, this field is populated from ETS.

Edit – 91029, Must be numeric!

To Correct – Verify typing and re-enter

Edit – 91061, Phone number must be 10 digits!

To Correct – Verify typing and re-enter.

Field Name: Ext

Description – Phone extension of requester

Format – Four numeric characters

Features – If provider is on the IHCP enrollment tracking system, this field is populated from ETS.

Edit – 91029, Must be numeric!

To Correct –Verify typing and re-enter.

Field Name: Contact

Description – Name of contact person for request

Format – 40 alphabetic characters

Features – If provider is on the IHCP enrollment tracking system, this field is populated from ETS.

Edit – 91031, Must be alphanumeric!

To Correct –Verify typing and re-enter.

Edit – 91037, Field is required!

To Correct – Enter contact name.

Field Name: Status

Description – Current status of provider's addendum

Format – 20 alphabetic characters

Features – Drop-down list box. Valid values include the following:

- Awaiting Initial Info
- Awaiting Additional Info
- State Review
- State Approved
- State Denied
- Enrolled
- Indiana Health Coverage Programs Enrollment in Progress
- EDS Denied
- Followup

Edit – 5146, Application Status finalized - No further editing!

To Correct – Occurs if provider is already enrolled as PMP and a status update is attempted. No correction necessary. Click **OK**.

Edit – 5162, RTP Addendum not signed.

To Correct – If the addendum is not signed, change status to "Awaiting additional info" and click **RTP Reasons**. If the addendum is signed, click **PMP Info** and then click the Addendum Signed box.

Edit – 5163, RTP Specialty not valid!

To Correct – If the provider file indicates no valid PMP specialties, change status to "EDS Denied" and finalize. If the provider does have a valid specialty, click **PMP Info** and then click the Managed Care Specialty box.

Edit – 5164, RTP Can not add service location! 2 on file!

To Correct – If the provider is requesting a third PMP service location, change status to "Awaiting additional info" and RTP addendum to provider. If the provider has only requested two service locations, click **PMP Info** and then click the Service Location box.

Edit – 5165, RTP Practice Type Not Indicated!

To Correct – If the provider did not indicate a practice type, change status to "Awaiting additional info" and click **RTP Reasons**. If the practice type is checked, click **PMP Info** and then click the Practice Type box.

Edit – 5166, RTP Hospital Admit Privileges!

To Correct – If the provider did not indicate admitting privileges or a relationship, change status to "Awaiting additional info" and click **RTP Reasons**. If the information is present, click **PMP Info** and then click the Hospital Admit Privileges box.

Edit – 5167, RTP Delivery Privileges!

To Correct – If the provider did not indicate delivery privileges or a relationship *and* the provider indicated they practice obstetrics, change status to "Awaiting additional info" and click **RTP Reasons**. If the information is present or not applicable, click **PMP Info** and then click the Delivery Privileges box.

Edit – 5168, RTP Invalid County for Managed Care!

To Correct – If the provider has no service locations in a PCCM county, change status to "EDS Denied" and finalize. If the provider does have a service location in a PCCM county, click **PMP Info** and then click the Valid County box.

Edit – 5169, RTP Weekly Hours Not Submitted!

To Correct – If a solo provider did not indicate at least 20 hours at each service location, change status to "Awaiting additional info" and click **RTP Reasons**. If the provider did indicate 20 hours or this is group provider, click **PMP Info** and then click the Weekly Hours Submitted box.

Edit – 5170, RTP Panel Size Not Submitted or Invalid!

To Correct – If the provider did not accept at least 150 recipients, change status to "Awaiting additional info" and click **RTP Reasons**. If the provider did indicate at least 150 recipients, click **PMP Info** and then click the Panel Size Submitted box.

Edit – 5171, RTP 24 Hour Phone Number Not Submitted.

To Correct – If the provider did not supply a 24-hour phone number, change status to "Awaiting additional info" and click **RTP Reasons**. If the provider did supply a phone number, click **PMP Info** and then click the 24 Hour Phone box.

Edit – 5192, PMP has already been enrolled!

TO CORRECT – No correction necessary. Click on OK button.

Edit – 5199, RTP Group Fee Designation not provided!

To Correct – If the group did not indicate how to pay the administrative fee, change status to "Awaiting additional info" and click **RTP Reasons**. If this was indicated or this is a solo provider, click **PMP Info** and then click the Group Fee Designation box.

Edit – 5200, RTP Group's Individual Apps. not provided!

To Correct – If all individual applications for a group are not present, change status to "Awaiting additional info" and click **RTP Reasons**. If the applications are present or this is a solo provider, click **PMP Info** and then click the Group Apps box.

Edit – 91037, Field is required!

To Correct – Select status from drop-down list box.

Edit – 91069, Must save current window before continuing!

To Correct – Click **Save**.

Field Name: Rqst Date

Description – Date addendum requested was entered

Format – Eight numeric characters

Features – None

Edit – 91037, Field is required!

To Correct – Enter request date.

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and re-enter.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and re-enter.

Edit – 91003, Date required!

To Correct –Enter request date

Field Name: Media

Description – Indicator of how request was received

Format – 10 alphabetic characters

Features – Drop-down list box. Valid values include:

- Fax
- Mail
- Phone

If provider is on the IHCP ETS, this field is populated from ETS.

Edit – 91037, Field is required!

To Correct – Select media from the drop-down list box.

Field Name: Follow Up

Description – Date follow-up letter was sent to non-responsive provider

Format – Eight numeric characters

Features – None

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and re-enter.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and re-enter.

Edit – 91003, Date is required!

To Correct – Enter follow-up letter date.

Field Name: Recv'd

Description – Date addendum was received from provider

Format – Eight numeric characters

Features – None

Edit – 5147, Received Date may not be less than Rqst Date

To Correct – Verify typing and re-enter.

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and re-enter.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and re-enter.

Edit – 91003, Date is required!

To Correct – Enter received date.

Field Name: Finalized Reason

Description – Description of a reason for denied status

Format – 250 alphabetic characters

Features– Drop-down list. Valid values include the following:

- The Medicaid provider number you submitted on the provider addendum is not a valid Medicaid provider number.
- Medicaid does not currently have a service location registered for you with a primary specialty consistent with the PMP program.
- The specialty you have indicated on your Medicaid application does not qualify you to become a Primary Medical Provider.
- You do not have hospital admitting privileges or an arrangement with another physician.
- You do not have delivery privileges or an arrangement with another physician.
- The Hoosier Healthwise program is not operating in the county of your service location.

Edit – 5139, Reason is required with Finalized date!

To Correct – Select finalized reason.

Edit – 5154, Description may not exceed 250 characters!

To Correct – Change reason to have less than 250 characters.

Edit – 5172, Please add Finalized Date with Finalized Reason!

To Correct – Enter finalized date.

Field Name: Sent

Description – Date last RTP letter was sent to provider

Format – Eight numeric characters

Features – None

Edit – 5138, Date may not be less than Received date!

To Correct – Verify typing and re-enter.

Edit – 5161, RTP date change No RTP Reason Messages

To Correct – Click **RTP Reasons** and enter RTP reasons.

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and re-enter.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and re-enter.

Edit – 91003, Date is required!

To Correct – Enter date.

Field Name: Count

Description – The number of RTP letters sent to provider

Format – Two numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Received

Description – Date on which EDS last received response to RTP letter

Format – Eight numeric characters

Features – None

Edit – 5138, Date may not be less than Received date!

To Correct – Verify typing and re-enter.

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and re-enter.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and re-enter.

Edit – 91003, Date is required!

To Correct – Enter date.

Field Name: Count

Description – The number of times information has been received from the provider

Format – Two numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Finalized Date

Description – Date addendum is finalized

Format – Eight numeric characters

Features – None

Edit – 5138, Date may not be less than Received date!

To Correct – Verify typing and re-enter.

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and re-enter.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and re-enter.

Edit – 91003, Date is required!

To Correct – Enter finalized date.

Field Name: Final Letter Sent

Description – Date final letter (approved or denied) is mailed to provider

Format – Eight numeric characters

Features – Protected, display only

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and re-enter.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and re-enter.

Edit – 91003, Date is required!

To Correct – Enter date.

Other Messages

Button: Enroll PMP

Edit – 5173, Provider is currently in the Indiana Health Coverage Programs Enrollment.

To Correct –Indicates provider is still in the IHCP ETS and not yet IHCP enrolled. No correction is needed; the provider cannot be enrolled until IHCP enrollment is final. Click **OK**.

Edit – 5194, Provider not on Indiana Health Coverage Programs files.

To Correct – Verify typing and re-enter if needed.

Edit – 5193, Application must be State Approved to enroll PMP

To Correct – Change status to State Approved.

System Information

PBL – PROV07.PBL

Window – W_PMP_APPLN_MAINT

Menu – M_PROV_LIST_UPDATE

Data Windows – DW_PMP_APPLN_MAINT

DW_ETN_INPUT

System Features

Click **PMP Info** to display the PMP Information window.

Click **RTP Info** to display the PMP Application RTP Reasons window.

Click on **Enroll PMP** to display the Primary Medical Provider Maintenance window.

Click **Save** to allow the PMP application information to be saved unless all required information was entered on the window.

Click **Exit** to close the PMP Application Maintenance window.

Section 9: PMP Information Window

Introduction

The PMP Information window is used by EDS Managed Care staff to ensure that the provider addendum has been completely reviewed prior to forwarding for OMPP review. This screen displays a checklist that the enrollment clerk must complete. If the clerk attempts to place the addendum in a State Review status without completing the checklist, the system does not update the status. This window is accessed from the PMP Application Maintenance Window by clicking **PMP Info**.

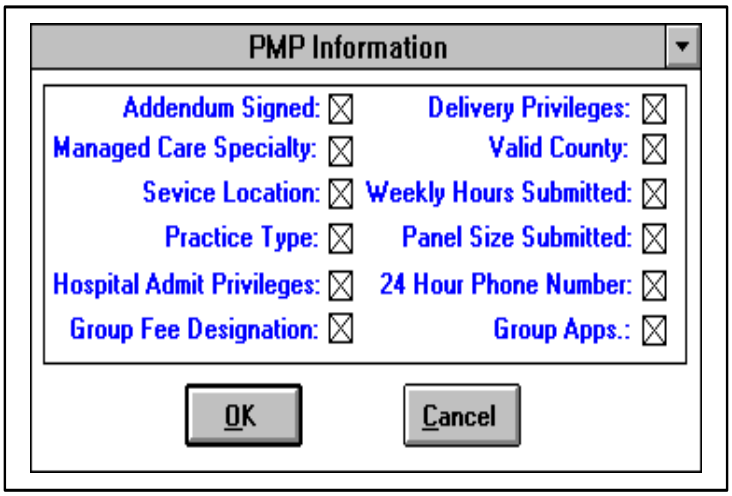

Figure 9.1 – PMP Information Window

Field Information

Field Name: Addendum Signed

Description –Indicates the clerk has reviewed the addendum and a signature was present

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Managed Care Specialty

Description – Indicates the clerk has reviewed the provider's file and determined it has an appropriate specialty for PMP status.

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: SERVICE LOCATION

Description – Indicates the clerk has reviewed the provider's file and determined it has two or fewer service locations on file. It may also indicate that the addendum provided a PMP service location to be deleted if the provider currently has two on file and is requesting a new one.

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Practice Type

Description – Indicates the clerk has reviewed the addendum and the provider has indicated a practice type

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Hospital Admit Privileges

Description – Indicates the clerk has reviewed the addendum and the provider indicated either having admitting privileges or a relationship with another provider

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Delivery Privileges

Description – Indicates the clerk has reviewed the addendum and the provider has indicated either having delivery privileges, a relationship with another provider, or that delivery privileges are not applicable to this provider. OB/GYN specialties and providers indicating they practice obstetrics must have privileges or a relationship.

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Valid County

Description – Indicates the clerk has reviewed the addendum and determined the provider's service locations are applicable for PCCM or that the provider is only requesting service locations for use under MCO

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Weekly Hours Submitted

Description – Indicates the clerk has reviewed the addendum and determined it is for a group practice type or an individual provider has shown 20 or more hours at each service location

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Panel Size Submitted

Description – Indicates the clerk has reviewed the addendum and determined that panel size is between 150 and 2000. If no panel size is indicated on the addendum, it is assumed the provider is willing to accept 2000 recipients.

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: 24 Hour Phone Number

Description – Indicates the clerk has reviewed the addendum and determined that a 24-hour phone number was provided

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Group Fee Designation

Description – Indicates the clerk has reviewed the addendum and the group has indicated how the administrative fee is to be paid, either to the group or to the individuals

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Group Apps.

Description – Indicates the clerk has reviewed the addendum and all individual provider PMP addenda are present for designated group members

Format– Checkbox

Features – None

Edits – None

To Correct – N/A

System Information

PBL – PROV07.PBL

Window – W_PMP_APPLN_POPUP

Menu – NONE

Data Windows – DW_PMP_APPLN_POPUP

System Features

Click **OK** to close and save the PMP Information window.

Click **Cancel** to close the PMP Information window. This does not save the information entered.

Section 10: Provider Search Window

Introduction

IFSSA and EDS use the Provider Search window to access provider records using flexible selection criteria. The provider record is selected by entering data in the desired search criteria field to include the following:

- Provider ID
- Name
- Tax ID
- License
- Medicare
- UPIN

When the data is entered, the user activates the search request by clicking **Search** or by selecting **Search** in the Options menu.

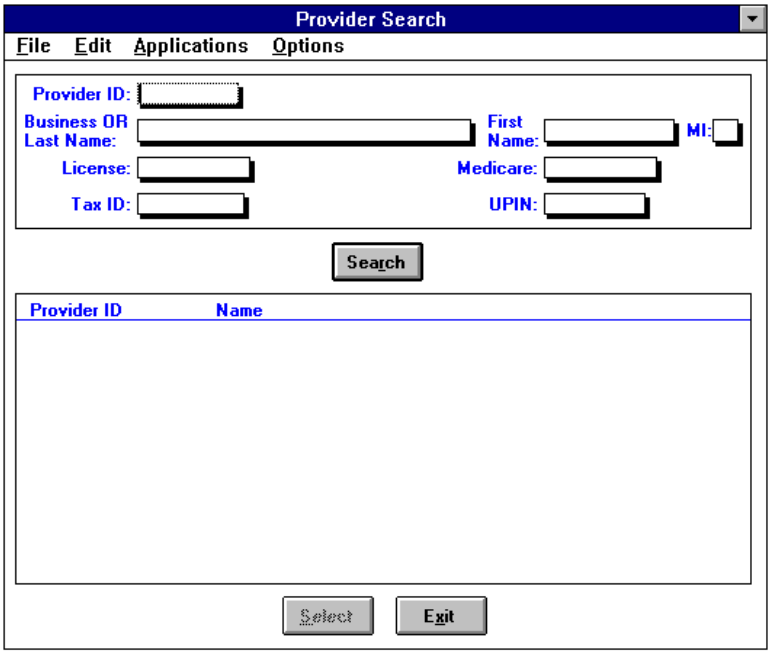

Figure 10.1 – Provider Search Window

File	Edit	Applications	Options
Select	Copy	Adhoc Reporting	Search
Print	Paste	Claims	Provider Labels
		Financial	
Exit	Cut		Provider List
Exit Indiana*AIM*		Managed Care	
		MARS	
		Prior Authorization	
		Provider	
		Recipient	
		Reference	
		Security	
		SURS	
		Third Party Liability	

Figure 10.2 – Provider Search Menu Tree

This is the menu tree for the Provider Search window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options for the Provider Search window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

Select – Opens the record of the highlighted provider

Print – Prints the screen, top window, or highlighted data window

Exit – Returns to the previous window

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the user to make modifications to the data entered.

Copy – Copies text for transfer to another area or application

Paste – Pastes text that was cut or copied from another area

Cut – Deletes the text and places it on the clipboard

Menu Selection: Applications

These menu option access the following functional areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting windows

Claims – Click to access the Claims windows

Financial – Click to access the Financial windows

Managed Care – Click to access the Managed Care windows

MARS – Click to access the MARS windows

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information windows

SURS – Click to access the SURS windows

Third Party Liability – Click to access the Third Party Liability windows

Menu Selection: Options

These menu selections access the following options in Indiana*AIM*:

Search – Initiates a search request

Provider Labels – Accesses the Provider Mailing Labels List window.

Provider List – Accesses the Provider Report List window

Field Information

Field Name: Provider ID

Description – Provider's identification number

Format – Nine numeric characters

Features – None

Edit – 4100, No match found!

To Correct – Verify typing. Provider ID was not found in the provider database.

Edit – 5093, Provider ID must be 9 characters!

To Correct – Verify typing. Provider ID must be nine characters.

Edit – 91006, Field is required!

To Correct – Verify typing. This is a required field when Provider ID is search selection.

Field Name: Business OR Last Name

Description – Provider's business or last name

Format – 25 alphabetic characters

Features – None

Edit – 91006, Field is required!

To Correct – Verify typing. This is a required field when Name is search selection.

Field Name: First Name

Description – Provider's first name

Format – 14 alphabetic characters

Features – None

Edit – 91006, Field is required!

To Correct – Verify typing. This is a required field when Name is search selection.

Field Name: MI

Description – Provider's middle initial

Format – One alphabetic character

Features – None

Edits –None

To Correct – N/A

Field Name: Tax ID

Description –SSN/FEIN

Format – Nine numeric characters

*Feature*s – None

Edit – 4100, No match found!

To Correct – Verify typing. SSN or FEIN number was not found in the provider database.

Edit – 5091, SSN must be 9 numeric digits!

To Correct – Verify typing. SSN must be nine numeric digits.

Edit – 91006, Field is required!

To Correct – Verify typing. This is a required field when SSN or FEIN is search selection.

Field Name: License

Description – License number of physician

Format – 10 numeric and alphabetic characters

Features – None

Edit – 4100, No match found!

To Correct – Verify typing. License number was not found in the provider database.

Edit – 5092, License must be 5-10 numeric digits!

To Correct – Verify typing. License must be 5-10 numeric digits.

Edit – 91006, Field is required!

To Correct – Verify typing. This is a required field.

Field Name: Medicare

Description – Provider's Medicare provider ID number

Format – Can be up to ten alphabetic and numeric characters.

Features – None

Edit – 4100, No match found!

To Correct – Verify typing. Medicare number was not found in the provider database.

Edit – 5065, Medicare number must be 6 characters!

To Correct – Verify typing. Medicare number must be 6 numeric characters.

Verify Field Name: UPIN

Description – Unique Provider Identifier Number

Format – Six alphabetic and numeric characters

Features – None

Edit – 91024, No match found!

To Correct – Verify typing. UPIN number was not found in the provider database.

Field Name: Search

Description – Option button chosen to initiate search of provider file

Format – N/A

Features – Option button

Edits – None

To Correct – N/A

Field Name: Provider ID

Description – Provider's identification number

Format – Nine numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Location

Description – Service location suffix

Format– One alphabetic character

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Name

Description – Provider's name

Format – 39 alphabetic characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Select

Description – Option button to select a provider once applicable providers have been displayed

Format – N/A

Features – Protected

System Information

PBL – PROV02.PBL

Window – W_PROVIDER_SEARCH

Menu – M_PROVIDER_SEARCH

Data Windows – DW_PROVIDER_SEARCH

DW_PROVIDER_SEARCH_ID

DW_PROVIDER_SEARCH NAME

DW_PROVIDER_SEARCH_SSN

DW_PROVIDER_SEARCH_LICENSE

DW_PROVIDER_SEARCH MEDICARE

DW_PROVIDER_SEARCH UPIN

System Features

When performing a search by name, either the last name, last and first names, last, first, and middle initial of the provider's name, or the business name of the provider may be entered. In each case, providers are listed alphabetically beginning with the first name greater than or equal to the value entered.

Section 11: Provider Base Window

Introduction

IFSSA and EDS use the Provider Base window to view, update or add a provider record and to access all other provider windows. Only authorized users with update privileges can add new information or change existing data. Provider information that is exclusive of a service location is viewed on the Provider Base window and the subsequent windows accessed by the option buttons on the Provider Base window.

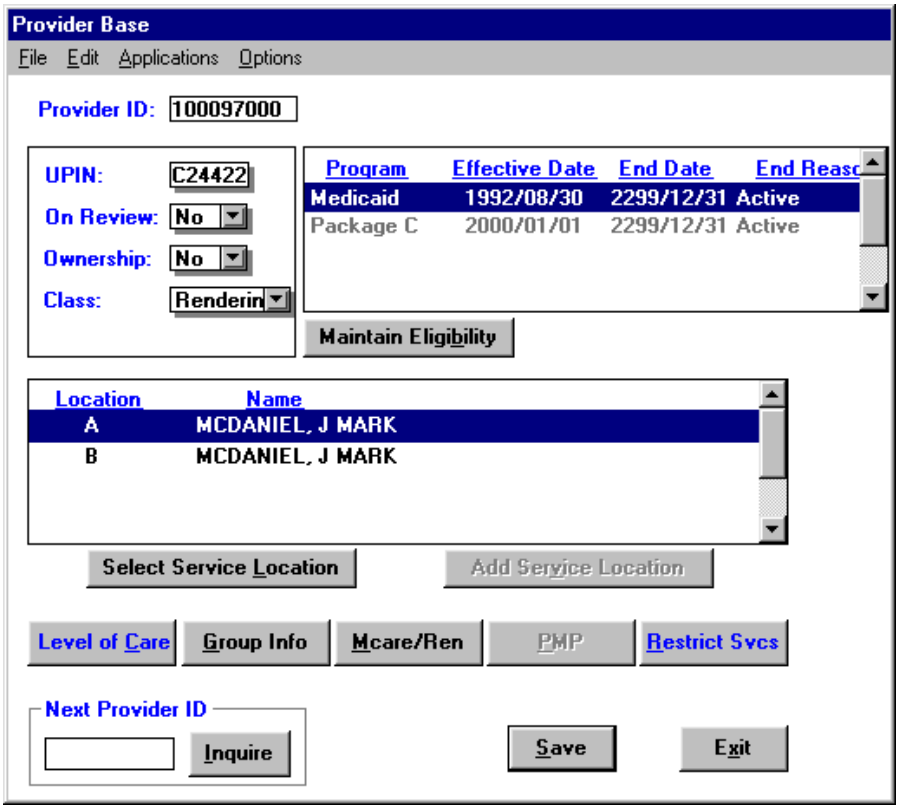

Figure 11.1 – Provider Base Window

File	Edit	Applications	Options
Save	Copy	Adhoc Reporting	Inquire
Print	Paste	Claims	Provider MCO's
Exit	Cut	Financial	MC Cert Code
Audit		Managed Care	Print RTP Letter
Exit Indaina*AIM*		MARS	Medicare/Rendering
		Prior Authorization	
		Provider	
		Recipient	
		Reference	
		Security	
		SURS	
		Third Party Liability	

Figure 11.2 – Provider Base Menu Tree

This is the menu tree for the Provider Base window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Provider Base window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

Save – Saves entered Provider Base information.

Print – Prints the screen, window or data window.

Exit – Returns the user to Provider Search window.

Audit – Accesses online audit trail windows.

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy –Transfers the copied text to another area.

Paste –Inserts text cut or copied from another area.

Cut – Removes text and places it on the clipboard.

Menu Selection: Applications

This menu selection accesses the following areas in IndianaAIM:

Adhoc Reporting – Click to access the Adhoc Reporting information

Claims – Click to access the Claims history files

Financial – Click to access the Financial windows

Managed Care – Click to access the Managed Care windows

MARS – Click to access the MARS information

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information

SURS – Click to access the SURS windows

Third Party Liability – Click to access the Third Party Liability windows

Menu Selection: Options

This menu selection selects different system functions from the menu bar.

Inquire – Selects another provider after entering the applicable provider number in the Next Provider ID field

Provider MCO's – Opens provider Managed Care windows

MC Cert Code – Opens the MC Cert Code window

Print RTP Letter – Accesses the Provider Change RTP Letter (PRV-9012-R)

Medicare/Rendering – Opens the Maintain Medicare Number window

Field Information

Field Name: Provider ID

Description – Provider's identification number

Format – Nine numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: UPIN

Description – Provider's Unique Provider Identifier Number (UPIN)

Format – Six alphabetic and numeric characters

Features – None

Edit – 5050, UPIN must be six digits!

To Correct – Verify typing. The UPIN must be six alphabetic and numeric characters.

Field Name: ON REVIEW

Description – Field indicating if the provider is currently on prepay review utilization with valid values to include Yes and No

Format – Two or Three alphabetic characters

Features – Drop-down list box

Edits – None

To Correct – N/A

Field Name: Ownership

Description – Field indicating whether the provider has a controlling ownership interest in any other IHCP provider facility or practice. Valid values include Yes and No.

Format – Two or Three alphabetic characters

Features – Drop-down list box

Edits – None

To Correct – N/A

Field Name: Class

Description – Type of billing classification for the provider.

Format – Valid values include the following:

- Billing
- Dual Role
- Group
- Rendering

Features – Drop-down box

Edits – N/A

To Correct – N/A

Field Name: Program

Description – Provider's enrollment in any health program or special program within IHCP. Valid values include the following:

- Medicaid
- IHCP 590
- Package C – This program is automatically added when the IHCP is given. It is a protected field.

Format – Eight alphabetic and numeric characters

Features – Protected display only

Edits – None

To Correct – N/A

Field Name: Effective Date

Description – Effective date of provider's enrollment status segment

Format – Eight numeric characters (YYYY/MM/DD)

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: End Date

Description – End date of provider's enrollment status segment

Format – Eight numeric characters (CCYY/MM/DD)

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: End Reason

Description – Provider's eligibility status to include the following:

- Enrolled (MMIS)
- Deactivated (MMIS)
- Deceased (MMIS)
- Decertified (MMIS)
- Inactive (MMIS)
- Moved OOS (MMIS)
- New Individual (MMIS)
- Retired (MMIS)
- Corporation
- Return Mail (MMIS)
- Suspended (MMIS)
- Deleted (MMIS)
- Term by HPB
- Term by IFSSA
- Term By Not Enroll.
- Term By Provider
- Active
- Retired
- Deceased
- Return Mail
- Term by HCFA
- Recertification Date
- Duplicate Enrollment
- Rend/Bill Conversion
- Term by OIG
- Term – Rendering Loc
- Out of Business
- Chapter 7 Bankruptcy
- Transferred Ownership

- Chapter 11 Bankruptcy
- Chapter 13 Bankruptcy

Format – 13 alphabetic characters

Features – Protected display only

Edits – None

To Correct – N/A

Field Name: Location

Description – Provider's service location suffix

Format – One alphabetic and numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Name

Description – Provider's name

Format – 39 alphabetic characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Next Provider ID

Description – If another provider record is desired, the user may view the record by entering the provider's identification number in this field.

Format – Nine numeric characters

Features – None

Edit – 91024, No Match Found!

To Correct – Verify typing. The provider number entered must be stored in the provider database.

Features – None

Edit – 91024, No Match Found!

To Correct – Verify typing. The provider number entered must be stored in the provider database.

Other functions

Field Name: Maintain Eligibility

Description – Option button chosen to update the providers Program, Effective Date, End Date, and End Reason Date.

Format – N/A

Features – Option button

Edits – None

To Correct – N/A

Field Name: Select Service Location

Description – Option button chosen to open the Provider Service Location window

Format – N/A

Features – Option button

Edits – None

To Correct – N/A

Field Name: Add Service Location

Description – Option button chosen to add service locations to the provider base

Format – N/A

Features – Option button

Edits – None

To Correct – N/A

Field Name: Level of Care

Description – Option button chosen to open the Level of Care Maintenance window.

Format – N/A

Features – Option button

Edit – 5151, Provider Type does not require Level of Care!

To Correct – Verify typing. If the provider type is not 01-06, information should not be entered in the Level of Care window.

Edit – 5152, Please add Service Location before Level of Care!

To Correct – Verify typing. Service location information should be entered before the level of care information.

Field Name: Group Info

Description – Option button chosen to open the Group Maintenance window

Format – N/A

Features – Option button

Edits – None

To Correct – N/A

Field Name: Mcare/Ren

Description – Option button chosen to open the Maintain Medicare Numbers window

Format – N/A

Features – Option button

Edits – None

To Correct – N/A

Field Name: PMP

Description – Option button chosen to open the PMP Service Location Enrollment List window

Format – N/A

Features – Option button

Edits – None

To Correct – N/A

Field Name: Restrict Svcs

Description – Option button chosen to open the Provider Restricted Services window

Format – N/A

Features – Option button

Edits – None

To Correct – N/A

Field Name: Save

Description – Option button chosen to save the information entered into the window

Format– N/A

Features – Option button

Edit – 5057, Level of Care is required for this provider type!

To Correct – Verify typing. The Provider Base window cannot be saved if information has not been entered into the Level of Care window and the provider is type 01-06.

Edit – 5058, Provider Service Location Required!

To Correct – Verify typing. The Provider Base window cannot be saved without entering information in the Provider Service Location window.

Edit – 5084, Provider Eligibility info is required!

To Correct – Verify typing. The Provider Base window cannot be saved without entering information in the Maintain Eligibility window.

System Information

PBL – PROV02.PBL

Window – W_PROVIDER_BASE

Menu – M_PROVIDER_BASE

Data Windows – DW_PROVIDER_BASE PROVIDER ID

DW_PROVIDER_ELIGIBILITY

DW_PROVIDER_SERV_LOC LIST

System Features

The lien indicator is controlled through the financial windows.

The text on the Group Info button may be black if information is contained in the Group Maintenance window; gray if information is contained in the Group Members Maintenance window; and blue if the provider does not have a group affiliation.

When adding a provider, the Save button on the base screen verifies that a Level of Care and Service Location segment exist before committing the changes. If they do not exist, error messages 5057 or 5058 are issued. In addition, if Level-of-Care, Group/Member, PMP or EFT information exists, verification is not performed to ensure that the active dates for each are within the date span for a provider program. If not within the date range, error message 5124 is issued.

The Level of Care, Medicare, PMP, and Restrict Svcs buttons are either black or dimmed to indicate whether segments of the corresponding type exist or not.

Section 12: Level of Care Maintenance Window

Introduction

IFSSA and EDS use the Level of Care Maintenance window to view or update provider specific level-of-care information as well as rates and long term care information for extended care facility providers. Only authorized users with update privileges have the ability to add new information or change existing data. This window is accessed through the Provider Base Window by clicking **Level of Care** or by entering **Alt+C**.

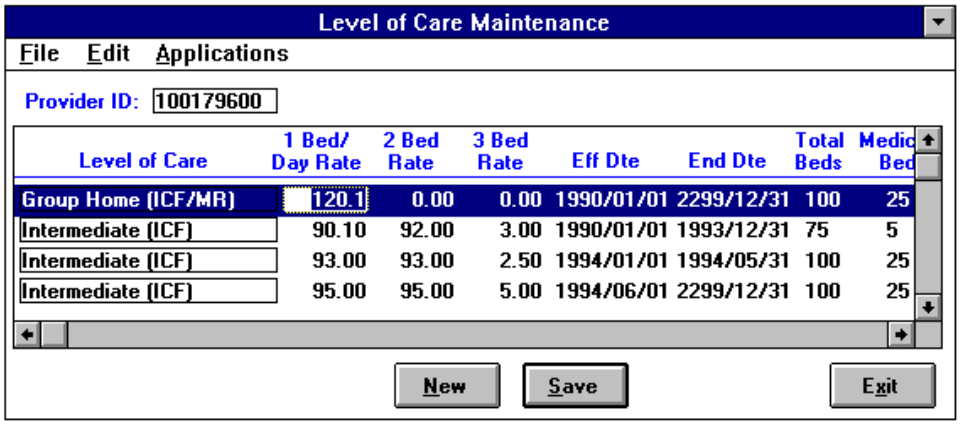

Figure 12.1 – Level of Care Maintenance Window

File	Edit	Applications
New	Copy	Adhoc Reporting
Save	Paste	Claims
Print	Cut	Financial
Exit		Managed Care
Audit		MARS
Exit Indiana*AIM*		Prior Authorization
		Provider
		Recipient
		Reference
		Security
		SURS
		Third Party Liability

Figure 12.2 – Level of Care Maintenance Menu Tree

This is the menu tree for the Level of Care Maintenance window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Level of Care Maintenance window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

New – Opens the Level of Care Maintenance window

Save – Saves entered information

Print – Prints the screen, top window, or data window

Exit – Returns to the Provider Base Window

Audit – Accesses the online audit trail windows

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy – Transfers the copied text to another area

Paste – Inserts text cut or copied from another area

Cut – Removes text and places it on the clipboard

Menu Selection: Applications

The menu options access the following functional areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting information

Claims – Click to access the Claims history files

Financial – Click to access the Financial windows

Managed Care – Click to access the Managed Care windows

MARS – Click to access the MARS information

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information

SURS – Click to access the SURS windows

Third Party Liability – Click to access the Third Party Liability windows

Field Information

Field Name: Provider ID

Description – Provider's identification number

Format – Nine alphabetic and numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Level of Care

Description – Provider's approved levels of care. Valid values include the following:

- Group Home (ICF/MR)
- Intermediate (HIV/AIDS)
- Intermediate (ICF)
- Nursing Facility
- Skilled (HIV/AIDS)
- Skilled (SNF)

Format – Can be as many as 18 alphabetic characters *Features* – Protected, display only

Edits – None

To Correct – N/A

Field Name: 1 Bed/Day Rate

Description – Provider's one bed daily room rate or day services rate (for spec. 031 & 033.)

Format – Six a numeric characters

Features – None

Edit – 91029, 1 Bed Rate must be numeric!

To Correct – Verify typing. The entry must be numeric. This field is only required for those facilities where it is applicable.

Field Name: 2 Bed Rate

Description – Provider's two-bed daily room rate

Format – Six numeric characters

Features – None

Edit – 91029, 2 Bed Rate must be numeric!

To Correct – Verify typing. The entry must be numeric. This field is only required for those facilities where it is applicable.

Field Name: 3 Bed Rate

Description – Provider's three-bed daily room rate

Format – Six numeric characters

Features – None

Edit – 91029, Add-On Rate must be numeric!

To Correct – Verify typing. The entry must be numeric. This field is only required for those facilities where it is applicable.

Field Name: Eff Date

Description – Effective date of the rate

Format – Eight numeric numeric characters

Features – None

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing. The MM must be less than or equal to 12. The DD must be less than or equal to 31, 30, 29, or 28, depending on the month and year. The date must also be entered as CCYYMMDD or YYMMDD.

Edit – 91002, Date Must Be Numeric!

To Correct – Verify typing. The entry must be numeric (0-9).

Edit – 91003, Date is required!

To Correct – Verify typing. Entry is required.

Field Name: End Dte

Description – End date of the rate

Format – Eight numeric numeric characters

Features – None

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing. The MM must be less than or equal to 12. The DD must be less than or equal to 31, 30, 29, or 28 depending on the month and year. The date must also be entered as CCYYMMDD or YYMMDD.

Edit – 91002, Date Must Be Numeric!

To Correct – Verify typing. The entry must be numeric (0-9).

Edit – 91003, Date is required!

To Correct – Verify typing. Entry is required.

Edit – 91020, End date must be > = Effective Date!

To Correct – Verify typing. The end date must be sequentially after or the same as the effective date.

Edit – 91030, Date segments may not overlap for same Level Of Care Segments!

To Correct – Verify typing. Date segments may not overlap for the same level of care.

Field Name: Total Beds

Description – The total number of beds in the facility

Format – Five numeric characters

Features – None

Edit – 91029 Total Beds must be numeric

To Correct – Verify typing. The entry must be numeric.

Field Name: Medicare Beds

Description – The total number of beds in the facility certified for Medicare patients

Format – Five numeric characters

Features – None

Edit – 91029, Medicare Beds must be numeric

To Correct – Verify typing. The entry must be numeric.

Field Name: Medicaid Beds

Description – The total number of beds in the facility certified for IHCP patients

Format – Five numeric characters

Features – None

Edit – 91029, Indiana Health Coverage Programs Beds must be numeric

To Correct – Verify typing. The entry must be numeric.

Field Name: LTC Cert Dte

Description – The date that the facility has been certified for long-term care by the Indiana State Department of Health (ISDH)

Format – Eight numeric numeric characters

Features – None

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing. The MM must be less than or equal to 12. The DD must be less than or equal to 31, 30, 29, or 28, depending on the month and year. The date must also be entered as CCYYMMDD or YYMMDD.

Edit – 91002, Date Must Be Numeric!

To Correct – Verify typing. The entry must be numeric (0-9).

Field Name: SDH Inspect Dte

Description – Date the facility was inspected by the ISDH

Format – Eight numeric numeric characters

Features – None

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing. The MM must be less than or equal to 12. The DD must be less than or equal to 31, 30, 29, or 28 depending on the month and year. The date must also be entered as CCYYMMDD or YYMMDD.

Edit – 91002, Date Must Be Numeric!

To Correct – Verify typing. The entry must be numeric (0-9).

System Information

PBL – PROV01.PBL

Window – W_PROVIDER_LEVEL_OF_CARE

Menu – M_PROVIDER_LEVEL_OF_CARE

Data Windows – DW_PROVIDER_LEVEL_OF_CARE

System Features

The Level of Care Data window includes **horizontal** scroll capability.

Section 13: Group Maintenance Window

Introduction

IFSSA and EDS use the Group Maintenance window to view or update provider enrollment in a group or in multiple groups if applicable. Only authorized users with update privileges have the ability to add new information or change existing data. If an individual provider belongs to a group (or multiple groups) the **Group Info** button on the Provider Base window is highlighted. This window can be accessed by clicking **Group Info** or by entering **Alt+G**.

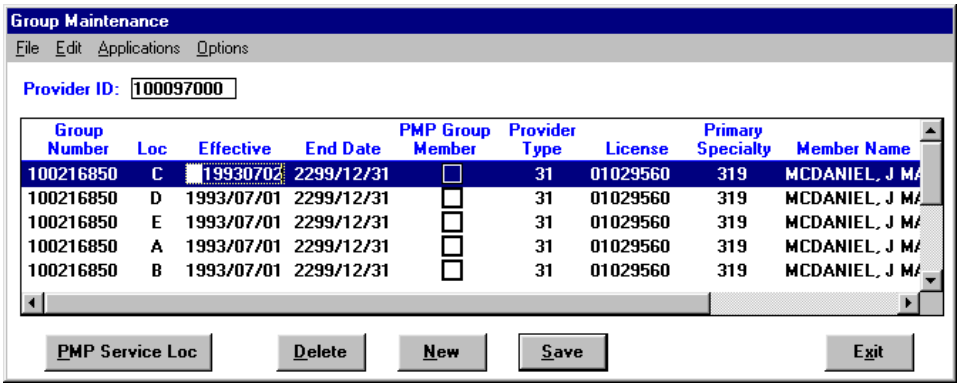

Figure 13.1 – Group Maintenance Window

File	Edit	Applications	Options
New	Copy	Adhoc Reporting	DEA
Save	Paste	Claims	Previous Nbrs
Print	Cut	Financial	Specialties
		Managed Care	
Exit		MARS	Update Name
Audit		Prior Authorization	Addtl License
Exit Indiana*AIM*		Provider	
		Recipient	
		Reference	
		Security	
		SURS	
		Third Party Liability	

Figure 13.2 – Group Maintenance Menu Tree

This is the menu tree for the Group Maintenance window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Group Maintenance window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

New – Opens the Group Maintenance window

Save – Saves entered information

Print – Prints the screen, top window, or data window.

Exit – Returns to the Provider Base window

Audit – Accesses the online audit trail windows

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy –Transfers copied text to another area

Paste – Inserts text cut or copied from another area

Cut – Removes text and places it on the clipboard

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting information

Claims – Click to access the Claims history files

Financial – Click to access the Financial windows

Managed Care – Click to access the Managed Care windows

MARS – Click to access MARS information

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information

SURS – Click to access the SURS windows.

Third Party Liability – Click to access the Third Party Liability windows

Menu Selection: Options

This menu selection allows the following functions from the menu bar.

DEA – Click to access the Group Member DEA Maintenance window

Previous Nbrs – Click to access the Group Member Previous Provider Number Maintenance window

Specialties – Click to access the Group Member Specialty Maintenance window

Update Name – Click to access the Member Name Selection window

Addtl License – Click to access the Provider Additional Licenses window

Field Information

Field Name: Provider ID

Description – Provider number

Format – Nine numeric characters

Features – Protected

Edits – None

To Correct – N/A

Field Name: Group Number

Description – Group provider ID number

Format – Nine numeric characters

Features – None

Edit – 5115, Provider number does not exist!

To Correct – Verify typing. Group number must be on provider table.

Edit – 5116, Provider is already member of a group!

To Correct – Verify typing. Ensure that provider group membership is not already established for the group being entered.

Edit – 5093, Provider ID must be 9 characters!

To Correct – Verify typing. Provider ID must be 9 characters in length.

Edit – 5114, Group Provider May Not Be Added To A Group!

To Correct – Verify typing. The provider number being entered must belong to an individual provider.

Field Name: Loc

Description – Provider's service location suffix

Format – One alphabetic character

Features – None

Edit – 5176, Service Location Invalid For This Provider!

To Correct – A valid service location for the provider is required.

Field Name: Effective

Description – Group membership effective date

Format– Eight numeric numeric characters

Features– None

Edit – 5025, Date must be in CCYY/MM/DD or YY/MM/DD format

To Correct – Verify typing. The MM must be less than or equal to 12. The DD must be less than or equal to 31, 30, 29, or 28 depending on the month and year.

Edit – 91020, End Date Must Be >= Effective Date

To Correct – Verify typing. The effective date must be sequentially before the end date.

Edit – 91003, Date is required!

To Correct – Verify typing. The effective date must be entered before trying to save the status.

Edit – 91030, Date segments may not overlap!

To Correct – Verify typing. The effective date of the current segment may not overlap the end date of the previous segment.

Field Name: End Date

Description – End date of group membership

Format – Eight numeric numeric characters

Features – Defaults to 22991231 (open ended) when adding new row

Edit – 5025, Date must be in CCYYMMDD or YYMMDD format

To correct – Verify typing. The MM must be less than or equal to 12. The DD must be less than or equal to 31, 30, 29, or 28 depending on the month and year.

Edit – 5026, End Date cannot be less than Effective Date

To Correct – Verify typing. The end date must be sequentially after the effective date.

Edit – 5123, Provider not enrolled for this date range!

To Correct – Verify typing. An effective cannot be entered if the provider is not enrolled on that date.

Edit – 91030, Date segments may not overlap!

To Correct – Verify typing. The end date of the current segment may not overlap the effective date of the same segment.

Field Name: PMP Group Member

Description – Indicator to display whether the provider is a PMP group member

Format – N/A

Features – Checkbox

Edit – 5196, PMP Group Data Missing!

To Correct – Verify typing. If the box is checked, PMP group data must be entered.

Edit – 5197, Group Provider Not Enrolled As A PMP Group!

To Correct – Verify typing. The group provider number entered is not enrolled as a PMP group.

Edit – 5198, Member Provider Not Enrolled As A PMP!

To Correct – Verify typing. The individual provider is not enrolled as a PMP.

Field Name: Provider Type

Description – Group member's provider type

Format – Two numeric characters

Features – Populated from the group member's information

Edits – None

To Correct – N/S

Field Name: License

Description – Group member's license number

Format – Appropriate alphabetic and numeric characters applicable to where the license was issued.

Features – Populated from the group member's information

Edits – None

To Correct – N/A

Field Name: Primary Specialty

Description – Group member's primary specialty

Format – Three numeric characters

Features – Populated from the group member's information

Edits – None

To Correct – N/A

Field Name: Member Name

Description – Group member's name

Format – 39 numeric characters

Features – None

Edits – None

To Correct – N/A

System Information

PBL – PROV01.PBL

Window – W_PROVIDER_GROUP

Menu – M_PROVIDER_GROUP

Data Windows – DW_PROVIDER_GROUP

System Features

Click **Group Info** to access the Provider Group Maintenance window.

Section 14: Maintain Rendering Medicare Numbers Window

Introduction

IFSSA and EDS use the Maintain Rendering Medicare Numbers window to view or update provider Medicare identification numbers if applicable. Only authorized users with update privileges have the ability to add new information or change existing data. The Maintain Rendering Medicare Numbers window are accessed through the Provider Base window by clicking **Mcare/Ren** or by entering **Alt+M**.

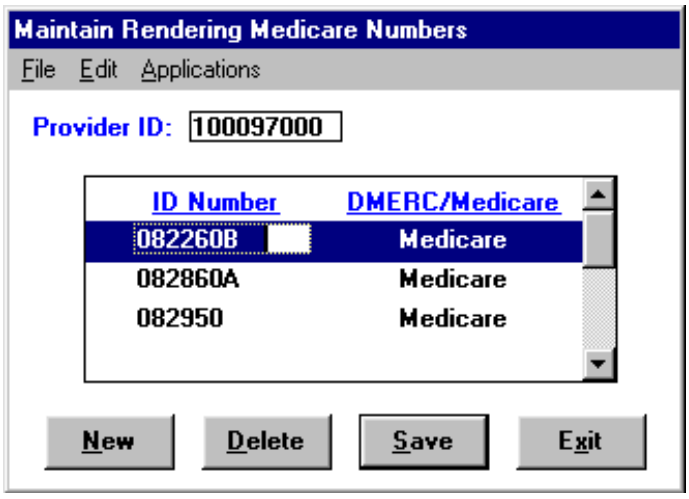

Figure 14.1 – Maintain Rendering Medicare Numbers Window

File	Edit	Applications
New	Copy	Adhoc Reporting
Save	Paste	Claims
Delete	Cut	Financial
Print		Managed Care
Exit		MARS
Audit		Prior Authorization
Exit Indiana*AIM*		Provider
		Recipient
		Reference
		Security
		SURS
		Third Party Liability

Figure 14.2 – Maintain Rendering Medicare Numbers Menu Tree

This is the menu tree for the Maintain Rendering Medicare Numbers window. All menus are in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Maintain Rendering Medicare Numbers window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined leter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

New – Opens the Maintain Rendering Medicare Numbers window

Save – Saves entered information

Delete – Deletes information already entered into the window

Print – Prints the screen, top window, or data window

Exit – Returns to the Provider Base window

Audit – Accesses the online audit trail windows

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy –Transfers the copied text to another area

Paste – Inserts text cut or copied from another area

Cut – Removes text and places it on the clipboard

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting information

Claims – Click to access the Claims history files

Financial – Click to access the Financial windows

Managed Care – Click to access the Managed Care windows

MARS – Click to access MARS information

Prior Authorization – Click to access the Prior Authorization windows

Provider – Click to access the Provider windows

Recipient – Click to access the Recipient windows

Reference – Click to access the Reference windows

Security – Click to access the Security information

SURS – Click to access the SURS windows

Third Party Liability – Click to access the Third Party Liability windows

Field Information

Field Name: Provider ID

Description – Provider's Medicare provider ID number

Format – Can be up to ten alphabetic and numeric characters.

Features – Protected / display only

Edits – None

To Correct – N/A

Field Name: ID NUMBER

Description – Provider's Medicare provider ID number

Format – Can be up to 10 alphabetic and numeric characters

Features – None

Edit – 91031, Must be alphanumeric

To Correct – Verify typing. Entry must be A-Z and/or 0-9.

Edit – 91032, May not be zero!

To Correct – Verify typing. Entry greater than zero is required.

Field Name: DMERC/Medicare

Description – DMERC/Medicare indicator

Format – Can be up to eight alphabetic characters.

Features – Protected display only. If the ID number is 10 characters in length, the field displays DMERC.

Edits – None

To Correct – N/A

System Information

PBL – PROV01.PBL

Window – W_PROVIDER_MEDICARE

Menu – M_PROVIDER_MEDICARE

Data Windows – DW_PROVIDER_MEDICARE

System Features

Click **Delete** to delete information already entered into the window.

The DMERC/Medicare indicator is automatically updated as an ID number is entered.

Section 15: PMP Service Location Enrollment List Window

Introduction

The PMP Service Location Enrollment List window displays all of the provider's service locations which are available for PCCM PMP status. Click **PMP** to access this window from the Provider Base window.

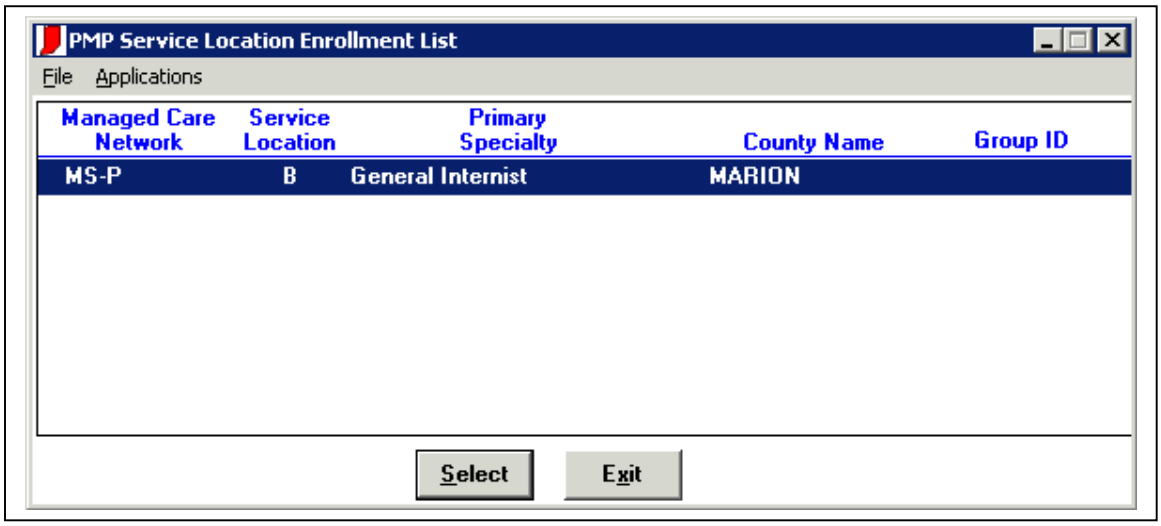

Figure 15.1 – PMP Service Location Enrollment List Window

File	Applications
Select	Adhoc Reporting
Print	Claims
Exit	Financial
Exit Indiana*AIM*	Managed Care
	MARS
	Prior Authorization
	Provider
	Recipient
	Reference
	Security
	SURS
	Third Party Liability

Figure 15.2 – PMP Service Location Enrollment List Menu Tree

This is the menu tree for the PMP Service Location Enrollment List window. The menu titles on this illustration reflect the overall menu commands and window options on the PMP Service Location Enrollment List window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

Select – Accesses the highlighted service location

Print – Prints the entire screen, the current window, or the accompanying data windows, if applicable.

Exit – Returns to the previous window

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting main menu

Claims – Click to access the Claims main menu

Financial – Click to access the Financial main menu

Managed Care – Click to access the Managed Care main menu

MARS – Click to access the MARS main menu

Prior Authorization – Click to access the Prior Authorization main menu

Provider – Click to access the Provider main menu

Recipient – Click to access the Recipient main menu

Reference – Click to access the Reference main menu

Security – Click to access the Security main menu

SURS – Click to access the SURS main menu

Third Party Liability – Click to access the Third Party Liability main menu

Field Information

Field Name: Service Location

Description –IHCP service location code

Format – One alphabetic character

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Primary Specialty

Description – Description of the specialty assigned to this service location

Format – 20 alphabetic characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: County Name

Description – County of this service location

Format – 20 alphabetic characters

Features– Protected, display only

Edits – None

To Correct – N/A

Field Name: Group ID

Description – Provider's group affiliation number

Format – Nine alphabetic characters

Features – Protected, display only

Edits – None

To Correct – N/A

System Information

PBL – PROV01.PBL

Window – W_PMP_SVC_LIST

Menu – M_BASE_LIST_RETRIEVE

Data Windows – DW_MC_SVC_LOC_LIST

System Features

Click **Select** to display the highlighted service location for updating.

Click **Exit** to exit the PMP Service Location Enrollment List window.

Section 16: PMP Service Location Maintenance Window

Introduction

The PMP Service Location Maintenance window allows the user to query or update information regarding a provider's particular service location. This window is accessed from the PMP Service Location Enrollment List window by clicking **Select**.

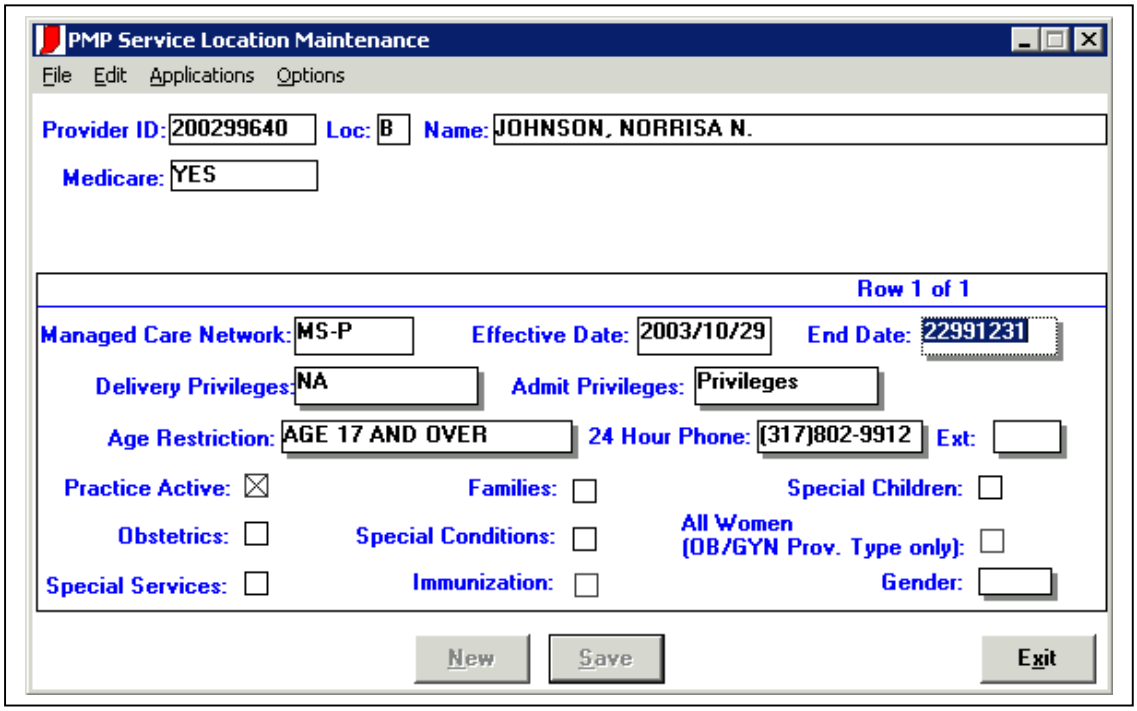

Figure 16.1 – PMP Service Location Maintenance Window

File	Edit	Applications	Options
New	Copy	Adhoc Reporting	Panel Size
Save	Paste	Claims	Enrollment Program
Print	Cut	Financial	MCO Enrollment List
Exit		Managed Care	Cert Code Maint
Audit		MARS	
Exit Indiana*AIM*		Prior Authorization	
		Provider	
		Recipient	
		Reference	
		Security	
		Third Party Liability	

Figure 16.2 – PMP Service Location Maintenance Menu Tree

This is the menu tree for the PMP Service Location Maintenance window. The menu titles on this illustration reflect the overall menu commands and window options on the PMP Service Location Maintenance window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.

A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

New – Highlights a new line and allows data entry for a new date segment

Save – Saves the current screen

Print – Prints the entire screen, the current window, or the accompanying data windows, if applicable

Exit – Returns to the PMP Application Maintenance screen

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy –Transfers the text to another area

Paste – Inserts text cut or copied from another area.

Cut – Removes text and places it on the clipboard

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting main menu

Claims – Click to access the Claims main menu

Financial – Click to access the Financial main menu

Managed Care – Click to access the Managed Care main menu

MARS – Click to access the MARS main menu

Prior Authorization – Click to access the Prior Authorization main menu

Provider – Click to access the Provider main menu

Recipient – Click to access the Recipient main menu

Reference – Click to access the Reference main menu

Security – Click to access the Security main menu

SURS – Click to access the SURS main menu

Third Party Liability – Click to access the Third Party Liability main menu

Menu Selection: Options

These menu options access the panel size and program enrollment windows.

Panel Size – Click to access the PMP Panel Size Maintenance window. This window displays the number of recipients the provider is willing to accept and the number of recipients assigned to the PMP.

Enrollment Program – Click to access the PMP Program Enrollment Maintenance window. This window shows the programming, which the provider participates.

Provider MCO Enrollment List – Click to access the Provider MCO Enrollment List window

Cert Code Maint – Click to access the Provider/Managed Care Certification Code Maintenance window

Field Information

Field Name: Provider ID

Description – IHCP identification number of the provider

Format – Nine numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Loc

Description – IHCP service location code

Format – One alphabetic character

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Name

Description – The name of the provider as listed on the provider tables

Format – 39 alphabetic characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: Managed Care Network

Description – Indicates under which program (Hoosier Healthwise MCO or PCCM, or Medicaid Select PCCM, or both RBMC and PCCM or MS-P) the service location is participating

Format – Four alphabetic characters

Features – None

Edit – 5189, County is not a PCCM county.

To Correct – No correction necessary. Verify addendum. If selected service location is correct, deny addendum.

Field Name: Effective Date

Description – Start date of the provider's PMP agreement

Format – Eight numeric characters

Features – None

Edit – 91001, Invalid Date!

To Correct – Verify typing and re-enter.

Edit – 91002, Date must be numeric!

To Correct –Verify typing and re-enter.

Edit – 91003, Date is required!

To Correct – Type date.

Field Name: End Date

Description – Date the provider's PMP status is terminated

Format – Eight numeric characters

Features – None

Edit – 5178, End Date < Effective Date! Not Allowed!

To Correct – Type an end date that is greater than the effective date.

Edit – 91001, Invalid Date!

To Correct – Verify typing and re-enter.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and re-enter.

Edit – 91003, Date is required!

To Correct – Type date.

Edit – 91030, Date segments may not overlap!

To Correct – Type an end date that does not fall within a previous segment.

Field Name: Admit Privileges

Description – Indicates if provider stated admitting privileges or admitting relationship on the addendum

Format – 12 alphabetic characters

Features – Drop-down list box

Valid values include:
Privileges
Relationship
None

Edit – 5177, PMP Provider must be able to admit patients!

To Correct – Verify typing and select either Privileges or Relationship. If addendum states none, deny application.

Field Name: Delivery Privileges

Description – Indicates if a provider who practices obstetrics stated delivery privileges or delivery relationship on the addendum. If provider does not practice obstetrics, value is listed as NA

Format – 12 alphabetic characters

Features – Drop-down list box. Valid values include the following:

- Privileges
- Relationship
- NA
- None

Edit – 5180, Please indicate the PMP delivery privileges!

To Correct – Verify typing and select either Privileges, Relationship, or N/A. If addendum states none and provider practices obstetrics, deny application.

Field Name: 24 Hour Phone

Description – Twenty-four-hour phone number for this service location

Format – 10 alphabetic characters

Features – None

Edit –5188, 24 Hour Phone Number must be 10 digits!

To Correct –Verify typing and retype.

Edit – 91029, Must be numeric!

To Correct –Verify typing and retype.

Field Name: Ext

Description – Extension for the 24-hour phone number

Format– Four alphabetic and numeric characters

Features – None

Edit – 91029, Must be numeric!

To Correct – Verify typing and retype

Field Name: Practice Active

Description – Indicates if the provider is accepting recipients under a given practice type. For example, a provider may be accepting recipients at this service location as solo provider. Therefore, his group type practice would be closed or inactive.

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Families

Description – Indicates if the provider accepts entire families

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Obstetrics

Description – Indicates if the provider practices obstetrics

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Special Conditions

Description – Indicates if the provider has special services for recipients with special conditions

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Special Services

Description – Indicates if the provider has special services available

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Immunization

Description – Indicates if provider expressed interest in vaccination program

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Age Restriction

Description – Indicates if the provider has age restrictions on his panel

Format – 17 alphabetic and neumeric characters

Features – Drop-down list box. Valid values include the following:

- No Age Restriction
- 0-12 Years of Age
- 13-20 Years of Age
- Age 21 and Over
- 0-20 Years of Age

Edits – None

To Correct – N/A

System Information

PBL – PROV01.PBL

Window – W_PMP_SERV_LOC

Menu – M_PMP_SERV_LOC

Data Windows – DW_PMP_SERV_LOC

System Features

Click **New** to display a blank window for data entry of a new PMP eligibility segment.

Click **Save** to save the information.

Click **Exit** to return to the Provider Service Location window.

Other System Messages

Edit – 8004, No changes keyed!, Save successful, Save unsuccessful

Button – Exit

Edit – 5183, Panel Size Record Required!

To Correct – Continue with enrollment and enter panel size.

Edit – 5185, Enrollment Program Record Required!

To Correct – Continue with enrollment and enter enrollment program.

System Information

PBL – PROV07.PBL

Window – W_PMP_MAIN

Menu – W_PMP_MAIN

Data Windows – DW_PMP_MAIN

DW_PROVIDER_DISPLAY

Section 17: PMP Panel Size Maintenance Window

Introduction

The PMP Panel Size Maintenance window allows queries or updates to a provider's accepted panel size. The window also displays the effective date a given panel size and the number of recipients assigned to a PMP by program as of the last census listing. This window is accessed from the Panel Size Menu Option from PMP Service Location Maintenance Window.

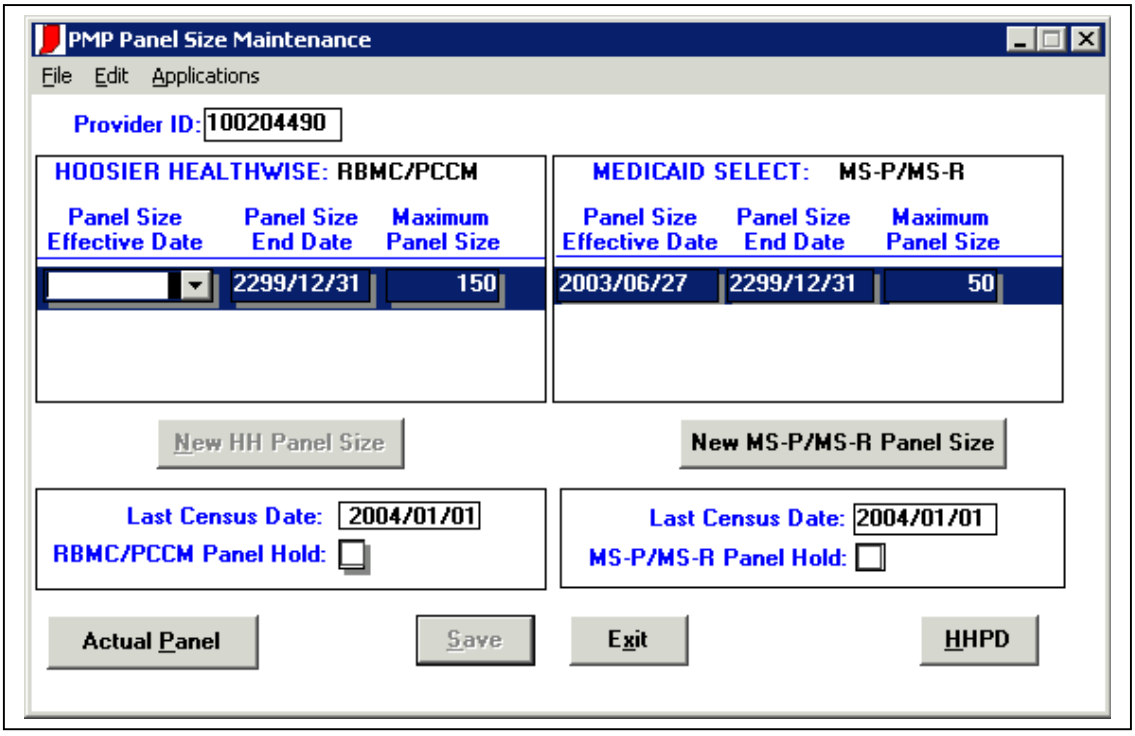

Figure 17.1 – PMP Panel Size Maintenance Window

File	Edit	Applications
New	Copy	Adhoc Reporting
Save	Paste	Claims
Print	Cut	Financial
Exit		Managed Care
Audit		MARS
Exit Indiana*AIM*		Prior Authorization
		Provider
		Recipient
		Reference
		Security
		SURS
		Third Party Liability

Figure 17.2 – PMP Panel Size Maintenance Menu Tree

This is an illustration of a menu tree for the PMP Panel Size Maintenance window. The menu titles on this illustration reflect the overall menu commands and window options on the PMP Panel Size Maintenance window.

Menu Bar

The menu bar is below the window title bar and contains the heading for the list of commands or window options.

The list of available commands or window options display in a drop-down box. If a command or window option is faded, the command or window option is not available.
A command or window option is selected by the following methods:

1. Click the **command or window option** title. A drop-down box displays. Click the command or window option.
2. Press the underlined letter using the proper case to access choices on the drop-down menu.

Menu Selection: File

This menu selection allows the following options:

New – Highlights a new line and allows data entry for a new date segment

Save – Saves current screen

Print – Prints the entire screen, the current window, or the accompanying data windows, if applicable

Exit – Returns to the previous window

Audit – Accesses the online audit trail windows

Exit IndianaAIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows the following options:

Copy – Transfers text from one area to another.

Paste – Inserts text cut or copied from another area.

Cut – Removes text and places it on the clipboard.

Menu Selection: Applications

This menu selection accesses the following areas in Indiana*AIM*:

Adhoc Reporting – Click to access the Adhoc Reporting main menu

Claims – Click to access the Claims main menu

Financial – Click to access the Financial main menu

Managed Care – Click to access the Managed Care main menu

MARS – Click to access the MARS main menu

Prior Authorization – Click to access the Prior Authorization main menu

Provider – Click to access the Provider main menu

*Recipien*t – Click to access the Recipient main menu

Reference – Click to access the Reference main menu

Security – Click to access the Security main menu

SURS – Click to access the SURS main menu

Third Party Liability – Click to access the Third Party Liability main menu

Field Information

Field Name: Provider ID

Description – IHCP identification number of the provider

Format – Nine numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field: Panel Size Effective Date for RBMC/PCCM

Description – Date when the provider accepted the given panel size

Format – Eight numeric characters

Features – Drop-down list box gives quarterly start dates for a panel size

Edit – 5184, Start date already on file! No duplicates allowed!

To Correct – Verify typing and select a start date not on file.

Edit – 5186, Panel Date must be within the Enrollment Period!

To Correct – Select an effective date within the provider's enrollment period.

Edit – 5215, Start Date must be a quarter date or elig start!

To Correct – Type an effective of either Jan, April, July, or Oct 1 or the PMP's eligibility start date.

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and retype.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and retype.

Edit – 91003, Date is required!

To Correct – Type date into field.

Field Name: Panel Size End Date for RBMC/PCCM

Description – Date the displayed panel size is no longer effective

Format – Eight numeric characters

Features – None

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and retype.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and retype.

Edit – 91003, Date is required!

To Correct – Type date into field.

Edit – 91030, Date segments may not overlap!

To Correct – Verify typing. PMP may not have two segments for the same time frame.

Edit – 5178, End Date < Effective Date! Not Allowed!

To Correct – Verify typing. End date must be greater than effective date.

Field Name: Maximum Panel Size for RBMC/PCCM

Description – Maximum number of recipients the provider is willing to accept

Format – Four alphabetic and numeric characters

Features – None

Edit – 5181, Panel Size can not be greater than 2000!

To Correct – Verify typing and retype.

Edit – 5182, Panel Size must be greater >= 150!

To Correct – Verify typing and re-enter. If addendum states between 1 and 149, RTP addendum. If addendum is blank, enter 2000.

Edit – 91029, Must be numeric!

To Correct – Verify typing and retype.

Field Panel Size: Effective Date for MS-P/MS-R

Description – Date when the provider accepted the given panel size

Format – Eight numeric characters

Features – Drop-down list box provides quarterly start dates for a panel size

Edit – 5184, Start date already on file! No duplicates allowed!

To Correct – Verify typing and select a start date not on file.

Edit – 5186, Panel Date must be within the Enrollment Period!

To Correct – Select an effective date within the provider's enrollment period.

Edit – 5215, Start Date must be a quarter date or elig start!

To Correct – Type an effective of either Jan, April, July, or Oct 1 or the PMP's eligibility start date.

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and retype.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and retype.

Edit – 91003, Date is required!

To Correct – Type date into field.

Field Name: Panel Size End Date for MS-P/MS-R

Description – The date the displayed panel size is no longer effective.

Format – Eight numeric characters

Features – None

Edit – 91001, Invalid Date (CCYYMMDD)!

To Correct – Verify typing and retype.

Edit – 91002, Date must be numeric!

To Correct – Verify typing and retype.

Edit – 91003, Date is required!

To Correct – Type date into field.

Edit – 91030, Date segments may not overlap!

To Correct – Verify typing. PMP may not have two segments for the same time frame.

Edit – 5178, End Date < Effective Date! Not Allowed!

To Correct – Verify typing. End date must be greater than effective date.

Field Name: Maximum Panel Size for MS-P/MS-R

Description – Maximum number of recipients the provider is willing to accept

Format – Four alphabetic and numeric characters

Features – None

Edit – 5181, Panel Size can not be greater than 2000!

To Correct – Verify typing and retype.

Edit – 5182, Panel Size must be greater >= 150!

To Correct – Verify typing and re-enter. If addendum states between 1 and 149, RTP addendum. If addendum is blank, enter 2000.

Edit – 91029, Must be numeric!

To Correct – Verify typing and retype.

Field Name: Last Census Date for RBMC/PCCM

Description – Date of the census to determine recipient assignment counts

Format – Eight numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: RBMC/PCCM

Description – Indicates the PMP's panel size is temporarily frozen at the PMP's request

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

Field Name: Last Census Date MS-P/MS-R

Description – Date of the census to determine recipient assignment counts

Format – Eight numeric characters

Features – Protected, display only

Edits – None

To Correct – N/A

Field Name: MS-P/MS-R

Description – Indicates the PMP's panel size is temporarily frozen at the PMP's request

Format – Checkbox

Features – None

Edits – None

To Correct – N/A

System Information

PBL – PROV01.PBL

Window – W_PMP_PANEL_SIZE

Menu – M_BASE_ DW_PMP_PANEL_SIZE

DW_PMP_ACT_PANEL

System Features

Click **New RBMC/PCCM** to add new row to RBMC/PCCM

Click **New MS-P/MS-R** to add new row to **MS-P/MS-R** Click **New HHPD** to add new row to HHPD

Click **Actual Panel** to access the PMP Actual Panel Size window.

Click **Save** to save the information.

Click **Exit** to return the user to the previous window.

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit who will obtain confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

1115(a) Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by CMS. See also *Health Care Financing Administration, Waiver*.

11971 State form 11971; see *8A*.

1261A Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*

1500 This is a claim form used by participating Indiana Health Coverage Programs (IHCP*)* providers to bill medical and medically related services. See also *CMS-1500*.

1902(a)(1) Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewideness*.

1902(a)(10) Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver*.

1902(a)(23) Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver.*

1902(r)(2) Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.

1903(m) Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts*.

1915(a) Section of the Social Security Act that states requirements for Medicaid.

1915(b) Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.

1915(c)	Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver.*
1915(c)(7)(b)	Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.
1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care*.
450A	Social Evaluation for Long Term Care Admission
450B	Certification by Physician for Long Term Care Services.
590 Program	A State health coverage program for institutionalized persons under the jurisdiction of the Division of Mental Health and Department of Health.
7748	State Form 7748, Medicaid Financial Report
8A	*DPW Form 8A (State Form 11971), Notice to Provider of Member Deductible*. Used to relay member spenddown information to providers when the date of service is the same as the spenddown met date.
AA	Anesthesia Assistant.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAC	Alternative or Augmentative Communication device.
AAP	American Academy of Pediatrics.
AAS	Atomic absorption spectrophotometer.
ABA	American Banking Association.
ABG	Arterial blood gas.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.

ACOG	American College of Obstetricians and Gynecologists.
ACS	Affiliated Computer Services. State Healthcare PBM. Pharmacy Benefits Manager, Drug Rebate Services.
ACSW	Academy of Certified Social Workers.
ADA	American Dental Association.
ADAP	AIDS Drug Assistance Program.
ADC	Adult day care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.
ADL	Activities of daily living.
Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children is replaced by Temporary Assistance to Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance members, who are 65 years old or older, or members under any other category who are entitled to benefits under Medicare.
AHF	Antihemophiliac factor.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act. Replaced by Temporary Assistance to Needy Families (TANF).
Aid to the Blind (AB)	A classification or category of members eligible for benefits under the IHCP.
AIDS	Acquired Immune Deficiency Syndrome.
AIM	Advanced Information Management.

ALJ	Administrative Law Judge.
allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ALS	Advanced life support.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARC	Association of Retarded Citizens.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.
Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
Attending Physician	The physician providing specialized or general medical care to a member.
Auditing Contractor	The entity under contract with the Office of Medicaid Policy and Planning (OMPP) to conduct audits of long-term-care facilities or other functions and activities as designated by OMPP.
auto assignment	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.

Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to verify member eligibility by phone.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from CMS about persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	A statement of charges for medical services, the submitted claim document, or electronic record; which may contain one or more services performed.
billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP member.
billing service	An entity under contract with a provider that prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
BLS	Basic Life Support.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.

Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
BQAMIS	Bureau of Quality Assurance Management Information System.
BSN	Bachelor of Science in Nursing.
BSW	Bachelor of Social Work.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of IHCP services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits and procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal; a document from the Indiana State Department of Health (ISDH).
C519	Authorization for Member Liability Deviation, generated by the Medicaid recipient's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given member per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
CARF	Commission on Accreditation of Rehabilitation Facilities
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)
case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.

Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP member is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).
CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider that submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CCSW	Certified Clinical Social Worker.
CDC	Centers for Disease Control.
CDFC	County Division of Family and Children.
CDPW	County Department of Public Welfare, which is changed to the County Offices of the Division of Family and Children.
CDT	Current Dental Terminology.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM members to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees and family members of military retirees, now known as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).

Children's Special Health Care Services (CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CHIP	Children's Health Insurance Program.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: CMS-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.
claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for IHCP claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP.
Cm	Centimeter.
CMHC	Community Mental Health Center.
CMI	Case Mix Index.
CMN	Certificate of Medical Necessity.
CMS	Centers for Medicare and Medicaid Services.
CMS-1500	CMS-approved standardized claim form used to bill professional services. Formerly referred to as HCFA-1500.
COB	Coordination of benefits.

co-insurance	The portion of Medicare-determined allowed charge that a Medicare member is required to pay for a covered medical service after the deductible has been met. The co-insurance or a percentage amount is paid by IHCP if the member is eligible for Medicaid. See also *Cost Sharing*.
Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915(c), Waiver*.
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP members certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
Contractor	Offeror with whom the State successfully negotiated a contract pursuant to *IC 12-1-7-17*. **Auditing Contractor** – The entity under contract with the OMPP to conduct audits of long-term-care facilities or other functions and activities as designated by the OMPP. **Fiscal Agent Contractor** – The offeror(s) with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities. **Rate-Setting Contractor** – Entities under contract with the OMPP to perform rate-setting activities for hospitals and long-term-care facilities.
conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
copayment or copay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.

core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services*.
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.
cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.
county office	County offices of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members subject to the limitations of the *Indiana Administrative Code* (IAC).
CP	Clinical psychologist.
CPAS	Claims processing assessment system. An automated claims analysis tool used by the State for contractor quality control reviews.
CPM	Continuous Passive Motion.
CPS	Child Protective Services.
CPT	Current Procedural Terminology.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central Processing Unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.

CRLD	Computer report to laser disk.
CRNA	Certified Registered Nurse Anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to IHCP benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for the IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
CSW	Certified Social Worker
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP program, including State staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
CVP	Central venous pressure.
D&E	Diagnostic and evaluation (in reference to services and providers).
DASS	Delivery and Support System.
data element	A specific unit of information having a unique meaning.
DC	Doctor of Chiropractic.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
DDE	Direct data entry.
DDS	Doctor of Dental Surgery.
deductible	Fixed amount that a Medicare member must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug Efficacy Study and Implementation, drug determined to be less than effective (LTE); not covered by the IHCP.
designee	A duly authorized representative of a person holding a superior position.

detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition*.
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through CMS.
DHS	Department of Human Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG*.
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.
direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.
disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DMHA	Division of Mental Health and Addictions.
DO	Doctor of Osteopathy.
DOB	Date of birth.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Family and Social Services Administration
DPW Form 8A	See *8A*.

DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
drug code	Code established to identify a particular drug covered by the IHCP.
Drug Efficacy Study and Implementation (DESI)	A drug determined to be less than effective (LTE) and not covered by the IHCP.
drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series number is usually associated with the acronym.
DSS	Decision Support System. A data extraction tool used to evaluate IHCP data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.
duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
E/M	Evaluation and Management.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and personal computers for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; most commonly, long-term care (LTC); or nursing home (NH), or nursing facility (NF).
ECM	Electronic claims management; overall management of claim transmittal via electronic media; related to ECS, EMC, ECC, and paperless claims.
ECS	Electronic claims submission. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EDS	Electronic Data Systems Corporation, the IHCP claims processing and third party liability contractor.

EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EIP	Early Intervention Program
eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
eligible member	Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.
eligible providers	Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.
EMS	Emergency medical services.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members. See also *MRN*.
EOP	Explanation of payment, term previously used by the IHCP for the claim summary statement – currently know as a remittance advice (RA). Other insurers continue to use the term for claim statements to providers.
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for IHCP-eligible members younger than 21 years old offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.
error code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.
ESRD	End Stage Renal Disease.

EST	Eastern Standard Time, which is also Indianapolis local time, is a constant in *the majority* of the state of Indiana. This means that from the last Sunday in April to the last Sunday in October Indianapolis is on the same time as the states observing Central Standard Time (CST), like Chicago. From the last Sunday in October to the last Sunday in April Indianapolis is on the same time as the states observing Eastern Standard Time (EST), like New York. This is because Indiana does not observe daylight savings time.
EVS	Eligibility Verification System. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice-response system.
exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.
FDB	First DataBank.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance*.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FFS	Fee-for-service.
FID	Federal Investigation Database.
field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
Fiscal Agent Contractor	The offeror with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities.

fiscal month	Monthly time interval in a fiscal year.
Fiscal Year	The designated annual reporting period for an entity: State of Indiana – July 1 through June 30 Federal – October 1 through September 30
FISS	Fiscal intermediary shared system.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility.*
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.
FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
FTE	Full time employee.
FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
GCN*SEQND	Generic code sequence number classification system.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.

Gm	Gram.
GPCI	Geographic practice cost index.
GPCPD	Governor's Planning Council for People with Disabilities.
GPI	Generic pricing indicator.
Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as "paper" and "manual".
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel, Inc. The IHCP prior authorization, surveillance and utilization review and medical policy contractor
HCFA-1500	CMS-approved standardized claim form used to bill professional services. Now referred to as CMS-1500.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	Healthcare Common Procedure Coding System. A uniform health care procedural coding system approved for use by CMS. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana's preventive care program for IHCP members younger than 21 years old. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.

HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.
HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC	Health insurance carrier number.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health insurance premium payments.
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organization.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management*.
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915(c)(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*

Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound members by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.
Hoosier Healthwise	Hoosier Healthwise is an IHCP managed care program that consists of two components including Primary Care Case Management (PCCM) and risk-based managed care (RBMC).
HOPA	Hospital outpatient area.
HPB	Health Professions Bureau.
HPSA	Health professional shortage area.
HPSB	Health Professions Service Bureau.
HRI	Health-related items.
HRR	High risk register (in relation to audiological screening).
HSA	Home service agency.
HSPP	Health services provider in psychology.
IAC	*Indiana Administrative Code – Indiana rules.* State government agency administrative procedures.
IC	Indiana Code – Indiana laws.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for IHCP-eligible, mentally retarded individuals.
ICHIA	Indiana Comprehensive Health Insurance Association, a health insuring organization for special situations.
ICLPPP	Indiana Childhood Lead Poisoning Prevention Program.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.

IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEMS	Indiana Emergency Medical Service.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IHCP	Indiana Health Coverage Program.
IMCA	Indiana Motor Carrier Authority.
IMCS	Indiana Motor Carrier Services.
IMD	Institutions for mental disease.
IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana Family and Social Service Administration (IFSSA)	The State agency responsible for the coordination and administration of social service programs in the state of Indiana. The OMPP, under Indiana Family and Social Security Administration (IFSSA), is the single State agency responsible for the administration of the IHCP.
Indiana State Department of Health (ISDH)	The State agency responsible for promotion of health; providing guidance on public health issues; ensuring the quality of health facilities and programs and the administration of certain health programs. The Bureau of Family Health Services is the bureau within the Indiana State Department of Health (ISDH) organization charged with the administration of the Children's Special Health Care Services Division (CSHCS) as well as the Maternal and Child Health Division (MCH) and the Division of Women, Infants, and Children (WIC).
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).

inquiry	Type of online screen programmed to display rather than enter information. Used to research information about members, providers, claims adjustments and cash transactions.
institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPAS	Indiana Pre-Admission Screening.
IPP	Individualized Program Plan..
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health; currently known as the Indiana State Department of Health.
ISDH	Indiana State Department of Health; previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.
ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.

Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
L	Liter.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
LCN	Letter control number.
LCSW	Licensed Clinical Social Worker.
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a member. A claim is made up for one or more line items for the same member.
LLP	Limited license practitioner.
LMFT	Licensed Marriage and Family Therapist.
LMHC	Licensed Mental Health Counselor.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed Practical Nurse.
LSL	Lower specification limit, pertains to quality control charts.
LSW	Licensed Social Worker.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to members.
LTE	Less than effective drugs.

M/M	Medicare/Medicaid.
MAC	Maximum allowable cost for drugs as specified by the federal government.
MAC	Monitored anesthesia care
managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
Managed Care PCCM	Members in the primary care case management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
Managed Care RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.
mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MCPD	A pilot program that was available in Marion county from January 1997 through December 1999. It was a voluntary risk-based managed care program for IHCP enrollees that were considered disabled or chronically ill according to the State's established criteria.
MCS	Managed Care Solutions (now called Lifemark Corporation).
MD	Medical Doctor.
MDS	Minimum data set.

Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a member's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency.*
Medicaid Select	A managed care program for the aged, blind and disabled population consisting of a Primary Care Case Management (PCCM) delivery system.
Medicaid State plan	See also *Single State Agency, Medicaid Plan.*
Medicaid-Medicare eligible	Member who is eligible for benefits under both Medicaid and Medicare. Members in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.
medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.

Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A or Part B for services authorized by Medicare Part A or Part B.
member	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP members. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Member*.
member relations	The activity within the single state agency that handles all relationships between the IHCP and individual member.
member restriction	A limitation or review status placed on a recipient that limits or controls access to the IHCP to a greater extent than for other nonrestricted members.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*.
mental retardation	Significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
MHS	Managed Health Services.
MI	Mental illness.
MI/DD	Mental illness and developmental disability.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral.
misutilization	Any usage of the IHCP by any of its providers or members not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
Ml	Milliliter.
MLOS	Mean Length of Stay.

MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM*.
MMRT	Medicaid Medical Review Team.
MOC	Memorandum of Collaboration; a Hoosier Healthwise document that provides a formal description of the terms of collaboration between the primary medical provider (PMP) and the preventive health care service provider (PHCSP). It also serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MR/DD	Mental retardation and developmentally disabled.
MRN	Medicare Remittance Notice. A form provided by Indiana*AIM* and sent to members. The MRN details the payment or denial of claims submitted by providers for services provided to members.
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team, unit which makes decision regarding Disability Determination.
MS	Mail stop.
MSN	Master of Science in Nursing.
MSS	Master of Social Sciences.
MSW	Master of Social Work.
MWU	Medicaid Waiver Unit, the IDDARS unit which manages the HCBS Waiver Programs.
NAS	Non-ambulatory service.
NASW	National Association of Social Workers.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.

NDDF	National Drug Data File.
NEC	Not elsewhere classified.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility; also seen as ECF, NH, and LTC.
NH	Nursing home; also seen as ECF, NF, and LTC.
NIH	National Institutes of Health.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver*.
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI)*.
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act.
OBRA-90	Omnibus Budget Reconciliation Act of 1990.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.

OD	Doctor of Optometry.
OFC	Office of Family and Children.
OIG	Office of the Inspector General.
OMNI	A point-of-sale device used by providers to scan member ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter, in reference to drugs.
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs IHCP functions under the direction of the single state agency. The single state agency may perform all IHCP functions itself or it may delegate certain functions to other processing agencies.
outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a IHCP member from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a IHCP member resulting from the failure of the contractor to use available information or to process correctly.

override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.
PA	Prior authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by the IHCP.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by IHCP that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.
Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary*.
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In*.
participant	One who participates in the IHCP as either a provider or a member of services.
participating members	Individuals who receive Title XIX services during a specified period of time.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve IHCP members and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.

PAS Form 4B	Pre-Admission Screening Notice of Assessment Determination form.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PC	Personal computer.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Members in the Primary Care Case Management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
PCN	Primary care network.
PCP	Primary Care Provider.
PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
PEN	Parenteral and enteral nutrition .
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device which enables the consumer to secure help in an emergency.

personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PET	Positron Emission Tomography.
PGA	Peer group average.
PHC	Primary home care. IHCP-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHCSP	Preventive health care services provider; a provider of well-child care, pre-natal care services, or care coordination services.
PHO	Physician hospital organization.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA*.
physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
PKU	Phenylketonuria.
Plan of Care	A formal plan developed to address the specific needs of an individual. It links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMF	Provider master file.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to IHCP members assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO)*.

PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
Premium	Due from member in order to be eligible for Package C.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.
prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
Prior Authorization or Prior Review and Approval	The procedure for the office's prior review and authorization, modification, or denial of payment for covered medical services and supplies within IHCP allowable charges. It is based on medical reasonableness, necessity, and other criteria as described in the *IAC Covered Services Rule* and *Medical Policy Rule* found in the *Appendix* to this manual.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.

profile	Total view of an individual provider's charges or a total view of services rendered to a member.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that is enrolled as a provider of services and provides a covered IHCP service to an IHCP member.
Provider Agreement	A contract between a provider and the OMPP setting out the terms and conditions of a provider's participation in the IHCP. It must be signed by the provider prior to any reimbursement for providing covered services to members.
provider enrollment application	Required document for all providers who provide services to IHCP members.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.
provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor or dentist.
PSRO	Professional standards review organization.
purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.

QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
Rate-Setting Contractor	An entity under contract with the OMPP to perform rate-setting activities.
RBA	Room and Board Assistance.
RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by the OMPP.
reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a member to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reimbursement	Payment made to a provider, pursuant to Federal and State law, as compensation for providing covered services to members.

reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance*.
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the member disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.
rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.
repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Retrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic
RID	Recipient Identification (ID) number; the unique number assigned to a member who is eligible for IHCP services.

risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool.*
RN	Registered Nurse.
RNC	Registered Nurse Clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment.
RPT	Registered physical therapist.
RPTS	Research Project Tracking System.
RR	Resident review.
RUG	Resource Utilization Group.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
RVU	Relative value unit.
SA/DE	State Authorization/Data Entry.
SBOH	State Board of Health; previous term for the State Department of Health.
SCP	Specialty care physicians.
screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
SED	Seriously emotionally disturbed.
SEH	Seriously emotionally handicapped.
selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.

service date	Actual date on which a service(s) was rendered to a particular member by a particular provider.
service limits	Maximum number of service units to which a member is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SI/IS	Severity of illness/intensity of services.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Severely mentally ill.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Sixth Omnibus Budget Reconciliation Act.
SOBRA	Omnibus Budget Reconciliation Act of 1986.
SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.
specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
Spend-down	Process whereby IHCP eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.

SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor.
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.
State	Spelled as shown, State refers to the state of Indiana and any of its departments or agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.
State Form 11971	See *8A*.
State Form 7748	Medicaid Financial Report, used for cost reporting.
State Medicaid Office	Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the IHCP in Indiana.
State Plan	The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.
status	Condition of a claim at a given time; such as paid, pended, denied, and so forth.

stop-loss insurance	Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125 percent of the amount expected in an average year. See also *Reinsurance*.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
submission	The act of a provider sending billings to EDS for payment.
subsystem	A Medicaid term that refers to one of the following (I)HIS processing components: member's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.
SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the Centers for Medicare and Medicaid Services (CMS) that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements: Statistical analysis Exception processing Provider and member profiles Retrospective detection of claims processing edit and audit failures and errors Retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards Retrospective detection of fraud and abuse by providers or members Sophisticated data and claim analysis including sampling and reporting General access and processing features General reports and output
Survey Agency	The ISDH is the designated survey agency responsible for surveying, monitoring, reviewing, and certifying institutional providers of service who request or agree to participate in the IHCP. The ISDH also certifies several other provider types. These types are discussed under the section titled; *State, County Contractor Responsibilities* included in this chapter.
suspended transaction	A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).

suspense file	Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).
systems analyst or engineer	Responsible for performing the following activities: Detailed system and program design System and program development Maintenance and modification analysis and resolution User needs analysis User training support Development of personal IHCP knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TBI	Traumatic brain injury.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.
TEFRA 134(a)	Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.
therapeutic classification	Code assigned to a group of drugs that possess similar therapeutic qualities.
third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or member of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible member for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.

Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.
Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all recipients to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirements of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the recipients to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services*.
TPN	Total Parenteral Nutrition.
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
TRICARE	Formerly known as the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees, and family members of military retirees.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.

UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
UM	Utilization management.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
UPC	Universal product code. Codes contained on the first data bank tape update or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization Review. A formal assessment of the medical necessity, efficiency, or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
USPHS	United States Public Health Service.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VA	Veterans Administration.
VFC	Vaccines for Children program.
VIP	Validation Improvement Plan.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
waiver	Waiver allows members to move from the traditional Medicaid environment to a less restrictive environment. Some of the statutory entitlements are waved for the member.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children younger than five years old.

workmen's compensation	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.
Y2K	Year 2000. Commonly used in computer system compliance issues.

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